

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 15501

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) BURLEY				2. Date of Death Month May Day 4 Year 1996				3. Time of Death 0849	
	4a. Facility Name (If not institution, give street and number) PENINSULA REGIONAL MEDICAL CENTER				4b. City, Town, or Location of Death SALISBURY				4c. County of Death WICOMICO	
Funeral Director	5. Social Security Number 214-30-8687		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 64 Yrs.		If Under 1 Year Months Days		If Under 24 Hrs. Hours Min.	
	8. Date of Birth (Month, Day, Year) Mar. 11, 1932		9. Birthplace (State or Foreign Country) Virginia		10a. Usual Residence of Decedent 10a. State MD 10b. County Somerset 10c. City, Town or Location West Ocean City 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number Box 9847		10f. Zip Code 21842	
To Be Completed by Funeral Director	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8th College (1-4or 5+)	
	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Sanitary Truck Driver		16b. Kind of Business/Industry City of Pocomoke		17. Father's Name (First, Middle, Last) Burley Collins, Sr.		18. Mother's Name (First, Middle, Maiden Surname) Alene Harmon		19. Informant's Name/Relationship (Type, Print) Beatrice Collins	
Physician /Medical Examiner	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Macedonia Church Cemetery		Date 5/11/96		20c. Location - City or Town, State Westover, MD		21. Signature of Funeral Service Licensee John A. Prince	
	22. Name and Address of Facility Bennie Smith Funeral Home 819 4th Street, Pocomoke City MD 21851		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. e. Cardiac arrest Due to (or as a consequence of): b. Diabetes Due to (or as a consequence of): c. Hypertension Due to (or as a consequence of): d. Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last		Approximate Interval Between Onset and Death yes yes		23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Medical Certification: To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	
	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how Injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.	
State Registrar	29b. Signature and title of certifier William Robins, M.D.		29c. License number 029749		29d. Date signed (Month, Day, Year) 5/7/96		30. Name and address of person who completed cause of death (Item 23e) (Type, Print) WILLIAM ROBINS, M.D. 1104 HEALING DR. SALISBURY, MD 21801		31. Date filed (Month, Day, Year) MAY 09 1996	
	32. Registrar's Signature John Davidson Randall									

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Registrar and Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a is marked "yes", any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit

96 15502

DHHH 16 Rev 6/95

11

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 15503

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) RHODA VIOLA CECIL				2. Date of Death Month Day Year April 29, 1996		3. Time of Death 12:45 PM		
	4a. Facility Name (If not Institution, give street and number) Memorial Hospital & Medical Center				4b. City, Town, or Location of Death Cumberland		4c. County of Death Allegany		
Funeral Director	5. Social Security Number 213-24-6576		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 84 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	6. Date of Birth (Month, Day, Year) Aug 24, 1911	9. Birthplace (State or Foreign Country) MD	
	Usual Residence of Decedent								
To Be Completed by Funeral Director	10a. State MD		10b. County Allegany		10c. City, Town or Location Cresaptown		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
	10e. Street and Number 14020 Louise Drive				10f. Zip Code 21502		10g. Citizen of What Country? USA		
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: white		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker		16b. Kind of Business/Industry Own Home		
	17. Father's Name (First, Middle, Last) Isaac Lease				18. Mother's Name (First, Middle, Maiden Surname) Susan (Huff)				
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Thomas Cecil--son				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14020 Louise Drive; Cresaptown, MD 21502				
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Lease Cemetery		Date 05/02		20c. Location - City or Town, State Cresaptown, MD		
	21. Signature of Funeral Service Licensee James F. Scarpelli				22. Name and Address of Facility Scarpelli Funeral Home Cumberland, MD 21502				
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Urosepsis Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Approximate interval Between Onset and Death 17 Days								
	23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Tumor of the Liver Metabolic Encephalopathy						24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify)					
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. Signature and title of certifier Robustiano Barrera		29c. License number D14865		29d. Date signed (Month, Day, Year) APRIL 30, 1996	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Robustiano Barrera Memorial Hospital Medical Building Cumberland, MD. 21502									
31. Date filed (Month, Day, Year) MAY 03 1996				32. Registrar's Signature John Davidson-Randall					

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 15504

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) HELEN MILDRED CUMMINGS				2. Date of Death Month Day Year APRIL 29, 1996		3. Time of Death 1815	
	4a. Facility Name (If not institution, give street and number) SACRED HEART HOSPITAL				4b. City, Town, or Location of Death CUMBERLAND		4c. County of Death ALLEGANY	
Funeral Director	5. Social Security Number 218 12 5187		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 74 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) JUNE 16, 1921	9. Birthplace (State or Foreign Country) MARYLAND
	Usual Residence of Decedent				10a. State MARYLAND		10b. County ALLEGANY	
To Be Completed by Funeral Director	10c. City, Town or Location FROSTBURG		10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		10e. Street and Number 30 BRADDOCK STREET		10f. Zip Code 21532	
	10g. Citizen of What Country? U.S.		11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:	
	14. Race - American Indian, Black, White, etc. Specify: WHITE		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 4 College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) HOUSEWIFE		16b. Kind of Business/Industry OWN HOME	
	17. Father's Name (First, Middle, Last) JESSE FULLER		18. Mother's Name (First, Middle, Maiden Surname) ETHA WALBERT		19a. Informant's Name/Relationship (Type, Print) JESSIE STEVENSON		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 23 GREENBRIER COURT, FROSTBURG, MD 21532	
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) FROSTBURG MEMORIAL PARK 5/2/96		20c. Location - City or Town, State FROSTBURG, MD 21532		21. Signature of Funeral Service Licensee <i>Mailey M. Sowers</i>	
	22. Name and Address of Facility SOWERS FUNERAL HOME, P.A.		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. MALIGNANT CARCINOID, TERMINAL ILEUM		23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
	24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined	
	28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <i>Chaz Wynn</i>	
	29c. License number 024951		29d. Date signed (Month, Day, Year) APRIL 30, 1996		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Chang OH, M.B. - 48 Tarn Terrace Frostburg, MD 21532		31. Date filed (Month, Day, Year) MAY 03 1996	
32. Registrar's Signature <i>Juli Davidson-Randall</i>								

Baltimore, Maryland 21215-0020

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Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

CONGESTIVE HEART FAILURE
CHRONIC OBSTRUCTIVE PULMONARY DIS.
DIABETES MELLITES

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 15505

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) JOHN JOSEPH DELPRIORE				2. Date of Death Month 5 Day 7 Year 96		3. Time of Death 2035	
	4a. Facility Name (If not Institution, give street and number) Atlantic General Hospital				4b. City, Town, or Location of Death Berlin		4c. County of Death Worcester	
Funeral Director	5. Social Security Number 101-03-7336		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 76 Yrs.		8. Date of Birth (Month, Day, Year) 11/15/19	
	9. Birthplace (State or Foreign Country) NY		10a. State MD		10b. County Worcester		10c. City, Town or Location Berlin	
10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number 18 Anchor Way Dr.		10f. Zip Code 21811		10g. Citizen of What Country? USA		
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: 1942-45		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: white		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Aviation Investigator		16b. Kind of Business/Industry Aircraft Safety				
17. Father's Name (First, Middle, Last) Pasquale DelPriore				18. Mother's Name (First, Middle, Maiden Surname) Marie Marro				
19a. Informant's Name/Relationship (Type, Print) Catherine DelPriore				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 18 Anchor Way Dr. Berlin, MD 21811				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) MD Veterans Cemetery 5/10/96		20c. Location - City or Town, State Hurlock, MD				
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility Burbage Funeral Home 108 Williams St. Berlin, MD 21811						
23a. Please enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. Asystole Due to (or as a consequence of): b. Cardiac Stenosis Due to (or as a consequence of): c. ACD myocardial infarction Due to (or as a consequence of): d. Alcoholism, Cardiac Valve Disease								
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown								
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1) Renal Failure and 2) Congest Heart Fail 3) Congest Cardiac								
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
29b. Signature and title of certifier 		29c. License number D02020		29d. Date signed (Month, Day, Year) 5/5/96				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) John G. Green MD Salisbury MD 21801								
31. Date filed (Month, Day, Year) MAY 09 1996		32. Registrar's Signature 						

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death, filing Maryland Department of Health and Mental Hygiene.

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Physician
/Medical
Examiner

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To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

96 15506

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Clarence Edward Dill				2. DATE OF DEATH MONTH DAY YEAR May 8, 1996		3. TIME OF DEATH 0101 A M	
4. SOCIAL SECURITY NUMBER 219-16-5231		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 72 YRS.		7. DATE OF BIRTH (Month, Day, Year) June 1, 1923	
9a. FACILITY NAME (If not institution, give street and number) 110 Normira Avenue				9b. CITY, TOWN OR LOCATION OF DEATH Elkton		9c. COUNTY OF DEATH Cecil	
RESIDENCE OF DECEDENT							
10a. STATE Maryland		10b. COUNTY Cecil		10c. CITY, TOWN OR LOCATION Elkton		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER 110 Normira Avenue				10f. ZIP CODE 21921		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES WW II		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) College (1-4 or 5+)				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Salesman		16b. KIND OF BUSINESS/INDUSTRY Retail Lumber	
17. FATHER'S NAME (First, Middle, Last) Sudler Dill, Sr.				16. MOTHER'S NAME (First, Middle, Maiden Surname) Mary George			
19a. INFORMANT'S NAME (Type/Print) Verona E. Dill				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 110 Normira Avenue, Elkton, Maryland 21921			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Cherry Hill Methodist Cem. 5/10/96		20c. LOCATION — City or Town, State Cherry Hill, Maryland			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Donald S. Hicks				22. NAME AND ADDRESS OF FACILITY Hicks Home for Funerals 103 W. Stockton Street, Elkton, MD 21921			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. PROBABLE CARDIAC ARREST DUE TO (OR AS A CONSEQUENCE OF): b. CORONARY ARTERY DISEASE DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF):							Approximate interval between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO	
		28d. DESCRIBE NOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER John J. G. M.D.				29c. LICENSE NUMBER AR C8004		29d. DATE SIGNED (Month, Day, Year) 5/9/96	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) YUKI IGARI M.D. PERRYPOINT VAMC, PERRYPOINT MD 21902							
31. DATE FILED (Month, Day, Year) MAY 10 1996				32. REGISTRAR'S SIGNATURE John Davidson Randall			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 15507

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) JOHN BERNARD DOBRY				2. Date of Death Month Day Year May 15 1996		3. Time of Death 12:20 a.m.	
	4a. Facility Name (If not institution, give street and number) 9747 Charles Street				4b. City, Town, or Location of Death La Plata		4c. County of Death Charles	
Funeral Director	5. Social Security Number 220-16-5272		8. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 71 Yrs.		If Under 1 Year Months Days	
	Usual Residence of Decedent		10a. State MD		10b. County Charles		10c. City, Town or Location LaPlata	
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		10e. Street and Number 9747 Charles St.		10f. Zip Code 20646		10g. Citizen of What Country? U.S.A.	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: WW II		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Civilian Personnel Classification Specialist		16b. Kind of Business/Industry N.O.S.			
	17. Father's Name (First, Middle, Last) Edward James Dobry				18. Mother's Name (First, Middle, Maiden Summa) Mignonette Adams Dobry			
	19a. Informant's Name/Relationship (Type, Print) Ramona Dobry				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. Box 493 LaPlata, MD 20646			
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Charles Mem. Gardens		20c. Location - City or Town, State 5/17/96 Leonardtown, MD			
	21. Signature of Funeral Service Licensee David C. Echols		22. Name and Address of Facility AREHART-ECHOLS FUNERAL HOME, INC. MOO945 P.O. Box 567 LaPlata, MD 20646					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. Bladder Cancer Due to (or as a consequence of): Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.							
	23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown							
	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No							
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No								
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 8 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
	28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how injury occurred					
	28f. Location (Street and Number or Rural Route Number, City or Town, State)							
Medical Certification: To Be Completed by Physician/Medical Examiner	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
	29b. Signature and title of certifier Krishan Mathur				29c. License number D28352		29d. Date signed (Month, Day, Year) May 15, 1996	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Krishan Mathur, M.D. - P.O. Box 2729, La Plata, MD 20646							
State Registrar	31. Date filed (Month, Day, Year) MAY 15 1996				32. Registrar's Signature John D. Randall			

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 15508

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) KATHRYN GRACE DEVER				2. Date of Death Month: MAY Day: 4 Year: 1996		3. Time of Death 16:10 P		
	4a. Facility Name (If not institution, give street and number) SACRED HEART HOSPITAL				4b. City, Town, or Location of Death CUMBERLAND		4c. County of Death ALLEGANY		
Funeral Director	5. Social Security Number 196-22-1051		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 83 Yrs.	If Under 1 Year Months: Days:	If Under 24 Hrs. Hours: Min.	8. Date of Birth (Month, Day, Year) Nov 3, 1912		
	9. Birthplace (State or Foreign Country) PA								
To Be Completed by Funeral Director	Usual Residence of Decedent								
	10a. State WV		10b. County Mineral		10c. City, Town or Location Wiley Ford			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	10e. Street and Number P.O. Box 78				10f. Zip Code 26767		10g. Citizen of What Country? USA		
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: white	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+)				16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker			16b. Kind of Business/Industry Own Home	
	17. Father's Name (First, Middle, Last) Louis H. Sutton				18. Mother's Name (First, Middle, Maiden Surname) Minnie D. (David)				
	19a. Informant's Name/Relationship (Type, Print) Wanda Sanders-Borsa/daughter				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) RD 2 Box 739 Holly Hill; New Freedom, PA 17349				
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Davis Memorial Cemetery		Date 05/07		
	20c. Location - City or Town, State Cumberland, MD								
	21. Signature of Funeral Service Licensee <i>James F. Scarpelli</i>				22. Name and Address of Facility Scarpelli Funeral Home Cumberland, MD 21502				
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Acute Sepsis							Approximate Interval Between Onset and Death 4 days	
	Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a consequence of):								
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of):								
	c. Due to (or as a consequence of):								
	d. Due to (or as a consequence of):								
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Alzheimer's disease								
	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown								
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No	
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
	26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)								
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
29b. Signature and title of certifier <i>Gary Wagoner</i>				29c. License number D22181		29d. Date signed (Month, Day, Year) MAY 5, 1996			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Gary Wagoner, M.D. 925 Bishop Walsh Road Cumberland, MD 21502									
State Registrar	31. Date filed (Month, Day, Year) MAY 06 1996				32. Registrar's Signature <i>John Davidson-Randall</i>				

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 15509

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

NOVELLA JONES DEAN

2. Date of Death

Month
MayDay
8Year
1996

3. Time of Death

0830

4a. Facility Name (If not institution, give street and number)

4828 Laurie Lane

4b. City, Town, or Location of Death

Woolford

4c. County of Death

Dorchester

Funeral
Director

5. Social Security Number

212-10-0255

6. Sex

1 ☐ M ☒ F

7. Age (In yrs. last birthday)

84

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Nov. 1 1911

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

Dorchester

10c. City, Town or Location

Woolford

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

4828 Laurie Lane

10f. Zip Code

21677

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: white

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4or 5+)

10

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

homemaker

16b. Kind of Business/Industry

17. Father's Name (First, Middle, Last)

John Wesley Jones

18. Mother's Name (First, Middle, Maiden Surname)

Jamesetta West

19a. Informant's Name/Relationship (Type, Print)

Mr. William S. Lake Jr. / son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

P.O. Box 1266, Woolford, MD 21677

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Salisbury Crematory

Date

5/9

20c. Location - City or Town, State

Salisbury, Md.

21. Signature of Funeral Service Licensee

Kenneth R. Thomas Jr.

22. Name and Address of Facility

Thomas Funeral Home

700 Locust St. Cambridge MD 21613

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. MYOCARDIAL INFARCTION
Due to (or as a consequence of):b. ASCVD
Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Approximate Interval Between Onset and Death

MINUTES

YRS

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

DEMENTIA, ADVANCED AGE

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No25. Was case referred to medical examiner?
1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☒ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 5 ☐ Pending Investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Hubert L. Fryer

29c. License number

D22773

29d. Date signed (Month, Day, Year)

5/9/96

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

HUBERT L. FRYER 503 BYRON ST CAMBRIDGE MD

31. Date filed (Month, Day, Year)

MAY 10 1996

32. Registrar's Signature

John Davidson-Randall

21613

State
Registrar

Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

96 15510

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Reuben H. Eby Jr.				2. DATE OF DEATH MONTH DAY YEAR May 11 1996		3. TIME OF DEATH 11:45 P	
4. SOCIAL SECURITY NUMBER 220 34 2429		5. SEX 1 <input type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 86 YRS.		7. DATE OF BIRTH (Month, Day, Year) June 7, 1909	
8. BIRTHPLACE (State or Foreign Country) Wash. Co., MD		9a. FACILITY NAME (If not institution, give street and number) Mennonite Old Peoples Home		9b. CITY, TOWN OR LOCATION OF DEATH Maugansville, MD		9c. COUNTY OF DEATH Washington	
10a. STATE MD				10b. COUNTY Washington		10c. CITY, TOWN OR LOCATION Maugansville, MD	
10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO				10e. STREET AND NUMBER 13436 Maugansville Rd.			
10f. ZIP CODE 21767				10g. CITIZEN OF WHAT COUNTRY? U S			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4 or 5+) 8		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Farmer		16b. KIND OF BUSINESS/INDUSTRY Farming			
17. FATHER'S NAME (First, Middle, Last) Reuben R. Eby				18. MOTHER'S NAME (First, Middle, Maiden Surname) Elizabeth Horst Eby			
19a. INFORMANT'S NAME (Type/Print) Mrs. Alice H. Eby				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) P. O. Box 670, Maugansville, MD 21767			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Reiff Mennonite Church Cemetery		20c. LOCATION — City or Town, State Cearfoss, MD		20d. DATE	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Robert T. May</i>				22. NAME AND ADDRESS OF FACILITY Minnich-Miller-May Funeral Home, 521 S. Washington St., Greencastle, PA 17225			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Congestive heart failure DUE TO (OR AS A CONSEQUENCE OF): b. Atherosclerotic heart disease DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST				Approximate interval Between Onset and Death hours			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Howard N. Weeks</i>				29c. LICENSE NUMBER D11266		29d. DATE SIGNED (Month, Day, Year) May 13, 1996	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Howard N. Weeks, M.D., 580 Northern Avenue, Hagerstown, MD 21742							
31. DATE FILED (Month, Day, Year) MAY 17 1996		32. REGISTRAR'S SIGNATURE <i>John Anderson</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

96 15511

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) EDNA MARIE ECKSTINE				2. DATE OF DEATH MONTH DAY YEAR May 14, 1996		3. TIME OF DEATH 10:35 P M	
4. SOCIAL SECURITY NUMBER 220-28-8450		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 88 YRS.		7. DATE OF BIRTH (Month, Day, Year) Jan. 7, 1908	
9a. FACILITY NAME (If not institution, give street and number) Washington County Hospital				9b. CITY, TOWN OR LOCATION OF DEATH Hagerstown		9c. COUNTY OF DEATH Washington	
10a. STATE Maryland		10b. COUNTY Washington		10c. CITY, TOWN OR LOCATION Hagerstown		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 19815 Evelyn Ave.				10f. ZIP CODE 21742		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4 or 5+) 8		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker		16b. KIND OF BUSINESS/INDUSTRY Home			
17. FATHER'S NAME (First, Middle, Last) Walter O. Himes				18. MOTHER'S NAME (First, Middle, Maiden Surname) Bessie Myrtle Stoops			
19a. INFORMANT'S NAME (Type/Print) Richard W. Eckstine				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. Box 57 Smithsburg, Md. 21783			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Smithsburg Cemetery May 19, 96		20c. LOCATION — City or Town, State Smithsburg, Md.		21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>J. Davis</i>	
22. NAME AND ADDRESS OF FACILITY Davis Funeral Home 12525 Bradbury Ave. Smithsburg, Md. 21783							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Hypertensive Cardio Vascular Disease DUE TO (OR AS A CONSEQUENCE OF): b. Pneumonia Bilateral DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							Approximate Interval Between Onset and Death years 7 days
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Senile Dementia Hypothyroid DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Edward W. Ditto, III</i>				29c. LICENSE NUMBER D01062		29d. DATE SIGNED (Month, Day, Year) May 15, 1996	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Edward W. Ditto, III, M.D. 217 W. Washington St. Hagerstown, Md 21740							
31. DATE FILED (Month, Day, Year) MAY 16 1996		32. REGISTRAR'S SIGNATURE <i>Julia Stueber-Randall</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

96 15512

1. FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1. DECEDENT'S NAME (First, Middle, Last) Robert L. Evans				2. DATE OF DEATH MONTH DAY YEAR May 3 1996		3. TIME OF DEATH 3:55AM M	
4. SOCIAL SECURITY NUMBER 234-64-2878		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 58 YRS.		7. DATE OF BIRTH (Month, Day, Year) Feb 16 1938	
8. BIRTHPLACE (State or Foreign Country) West Virginia				9a. FACILITY NAME (If not institution, give street and number) 19715 Sutherland Lane		9b. CITY, TOWN OR LOCATION OF DEATH Barton	
9c. COUNTY OF DEATH Allegany				10a. STATE Maryland		10b. COUNTY Allegany	
10c. CITY, TOWN OR LOCATION Barton				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER 19715 Sutherland Lane	
10f. ZIP CODE 21521				10g. CITIZEN OF WHAT COUNTRY? United States		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:			
14. RACE — American Indian, Black, White, etc. Specify: White				15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Unknown			
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Coal Miner				16b. KIND OF BUSINESS/INDUSTRY Coal Mining			
17. FATHER'S NAME (First, Middle, Last) Arlie Ward Evans				18. MOTHER'S NAME (First, Middle, Maiden Surname) Fay Veronica Trenter			
19a. INFORMANT'S NAME (Type/Print) Shelva Jean Evans				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19715 Sutherland Lane Barton, Md. 21521			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Laurel Hill Cemetery 55+96 Barton, Md.			
20c. LOCATION — City or Town, State				21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Wayne Boal</i>			
22. NAME AND ADDRESS OF FACILITY Boal Funeral Home 111 Church St. Westernport, Md.				23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>Arteriosclerotic cardiovascular heart disease</u> Uk b. <u>Diabetes</u> c. d. Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO			
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO 28d. DESCRIBE NOW INJURY OCCURRED 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. SIGNATURE AND TITLE OF CERTIFIER <i>Paul Snow</i> Dpty Med Ex D09157 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) May 3, 1996			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Paul Snow, M.D. 124 w 3rd st Cumb MD 21502				31. DATE FILED (Month, Day, Year) MAY 07 1996			
32. REGISTRAR'S SIGNATURE <i>Johi Andrew-Randall</i>							

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 15513

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) ALICE MAY				2. Date of Death Month May Day 11 Year 1996				3. Time of Death 1748									
	4a. Facility Name (If not institution, give street and number) PENINSULA REGIONAL MEDICAL CENTER				4b. City, Town, or Location of Death SALISBURY				4c. County of Death WICOMICO									
Funeral Director	5. Social Security Number 213-14-1703		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 76 Yrs.		8. Date of Birth (Month, Day, Year) 1/27/20		9. Birthplace (State or Foreign Country) MD									
	Usual Residence of Decedent																	
To Be Completed by Funeral Director	10a. State MD		10b. County Worcester		10c. City, Town or Location Berlin				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No									
	10e. Street and Number 11317 Worcester Highway				10f. Zip Code 21811		10g. Citizen of What Country? USA											
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: white										
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 5 College (1-4 or 5+)			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Nurse				16b. Kind of Business/Industry Healthcare										
	17. Father's Name (First, Middle, Last) Jacob M. Adkins				18. Mother's Name (First, Middle, Maiden Surname) Alice Laws													
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Wilson Fisher				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11317 Worcester Hwy. Berlin, MD 21811													
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Evergreen Cemetery		Date 5/14/96		20c. Location - City or Town, State Berlin, MD									
	21. Signature of Funeral Service Licensee <i>[Signature]</i>				22. Name and Address of Facility Burbage Funeral Home 108 Williams St. Berlin, MD 21811													
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or organ failure. List only one cause on each line.																	
	<table border="1"> <tr> <td rowspan="4">Immediate Cause (Final disease or condition resulting in death)</td> <td>a. <i>Asphyxia</i></td> <td>Approximate interval Between Onset and Death</td> </tr> <tr> <td>b. <i>Cardiac Shock</i></td> <td><i>None</i></td> </tr> <tr> <td>c. <i>Acute Myocardial Infarction</i></td> <td><i>None</i></td> </tr> <tr> <td>d. <i>Alcohol Intoxication</i></td> <td><i>Yes</i></td> </tr> </table>										Immediate Cause (Final disease or condition resulting in death)	a. <i>Asphyxia</i>	Approximate interval Between Onset and Death	b. <i>Cardiac Shock</i>	<i>None</i>	c. <i>Acute Myocardial Infarction</i>	<i>None</i>	d. <i>Alcohol Intoxication</i>
Immediate Cause (Final disease or condition resulting in death)	a. <i>Asphyxia</i>	Approximate interval Between Onset and Death																
	b. <i>Cardiac Shock</i>	<i>None</i>																
	c. <i>Acute Myocardial Infarction</i>	<i>None</i>																
	d. <i>Alcohol Intoxication</i>	<i>Yes</i>																
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown										
								24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No										
								24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No										
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)																
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred										
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)												
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <i>John S. Lee MD</i>		29c. License number D02020		29d. Date signed (Month, Day, Year) 5/12/96												
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) John G. Green MD Peninsula Regional Med Ctr																		
31. Date filed (Month, Day, Year) MAY 14 1996		32. Registrar's Signature <i>John Davidson Randall</i>																

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 15514

Certificate of Death

Reg. No.

Physician
/Medical
ExaminerFuneral
Director

1. Decedent's Name (First, Middle, Last) MAXWELL EDWARD GRIM				2. Date of Death Month MAY Day 9 Year 1996		3. Time of Death 12:35	
4a. Facility Name (If not institution, give street and number) WASHINGTON COUNTY HOSPITAL				4b. City, Town, or Location of Death HAGERSTOWN		4c. County of Death WASHINGTON	
5. Social Security Number 212-14-6478		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 77 Yrs.		8. Date of Birth (Month, Day, Year) MARCH 19, 1919	
9. Birthplace (State or Foreign Country) MARYLAND							
Usual Residence of Decedent							
10a. State MARYLAND		10b. County WASHINGTON		10c. City, Town or Location SHARPSBURG		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10e. Street and Number 115 WEST ANTIETAM STREET				10f. Zip Code 21782		10g. Citizen of What Country? U.S.A.	
11. Marital Status <input type="checkbox"/> Navar Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No 1940- If Yes, Give Year or Dates: 1945		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: WHITE	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) AUTO BODY MECHANIC		16b. Kind of Business/Industry AUTO DEALERSHIP	
17. Father's Name (First, Middle, Last) THOMAS FRANKLIN GRIM				18. Mother's Name (First, Middle, Maiden Surname) BESSIE ISABELL EICHELBERGER			
19a. Informant's Name/Relationship (Type, Print) GWENDOLYN V. GRIM/SPOUSE				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. BOX 56, SHARPSBURG, MARYLAND 21782			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) MOUNTAIN VIEW CEMETERY		Data 5/13/96		20c. Location - City or Town, State SHARPSBURG, MARYLAND	
21. Signature of Funeral Service Licensed <i>Paul M. Dean</i> Paul M. Dean				22. Name and Address of Facility BAST FUNERAL HOME 7606 Old National Pike Boonsboro, MD 21713			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Congestive cardiomyopathy Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Uremia due to renal failure Chronic atrial fibrillation							
Approximate Interval Between Onset and Death 5 months							
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Diabetes mellitus, type II. Uremia due to renal failure Chronic atrial fibrillation						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown	
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
28d. Describe how injury occurred				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			
28f. Location (Street and Number or Rural Route Number, City or Town, State)							
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. Signature and title of certifier <i>R. L. Kyler MD</i>				29c. License number D26579		29d. Date signed (Month, Day, Year) 5/9/96	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) R.L. Kyler MD 747 Northern Avenue, Hagerstown, Maryland 21742							
31. Date filed (Month, Day, Year) MAY 10 1996				32. Registrar's Signature <i>John Davidson-Rodell</i>			

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural," or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.


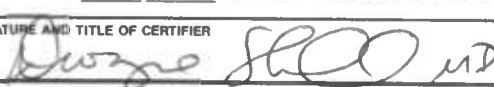

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State
Registrar

96 15515

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Commodore Roscoe Green				2. DATE OF DEATH MONTH May DAY 11 , YEAR 1996		3. TIME OF DEATH 5:00 P M	
4. SOCIAL SECURITY NUMBER 219-01-2034		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 84 YRS.		7. DATE OF BIRTH (Month, Day, Year) Sept. 22, 1911	
8. BIRTHPLACE (State or Foreign Country) Maryland				9a. FACILITY NAME (If not institution, give street and number) 6 Blue Mt. Estates		9b. CITY, TOWN OR LOCATION OF DEATH Smithsburg	
9c. COUNTY OF DEATH Washington				10a. STATE Md.		10b. COUNTY Washington	
10c. CITY, TOWN OR LOCATION Smithsburg				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		10e. STREET AND NUMBER 6 Blue Mt. Estates	
10f. ZIP CODE 21783				10g. CITIZEN OF WHAT COUNTRY? U.S.A			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES No		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 7 College (1-4 or 5+) 				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Brick Layer		16b. KIND OF BUSINESS/INDUSTRY Homes	
17. FATHER'S NAME (First, Middle, Last) Aquilla N. Green				18. MOTHER'S NAME (First, Middle, Maiden Surname) Grace M. Nisner			
19a. INFORMANT'S NAME (Type/Print) Fannie Hays				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 23605 Foxville Rd. Smithsburg, Md. 21783			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Smithsburg Crematory May 13, 96		20c. LOCATION — City or Town, State Smithsburg, Md.		21. SIGNATURE OF FUNERAL SERVICE LICENSEE 	
22. NAME AND ADDRESS OF FACILITY Davis Funeral Home 12525 Bradbury Ave Smithsburg, Md. 21783				23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. Atherosclerotic Coronary Vascular Disease DUE TO (OR AS A CONSEQUENCE OF): b. Aortic Stenosis - Moderate DUE TO (OR AS A CONSEQUENCE OF): c. Diabetes Mellitus - Type II DUE TO (OR AS A CONSEQUENCE OF): d. Essential Thrombocytosis			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Homicide 8 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER  MD				29c. LICENSE NUMBER D45472		29d. DATE SIGNED (Month, Day, Year) May	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Dwayne Shubert MD Smithsburg Maryland 21783							
31. DATE FILED (Month, Day, Year) MAY 13 1996				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

96 15516

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) ANGELO - - GLORIOSO				2. DATE OF DEATH MONTH May DAY 7 YEAR 1996		3. TIME OF DEATH 7:30 P.M.	
4. SOCIAL SECURITY NUMBER 216-12-3445		5. SEX 1 <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 74 YRS.		7. DATE OF BIRTH (Month, Day, Year) June 1, 1921	
8. BIRTHPLACE (State or Foreign Country) Colorado		9a. FACILITY NAME (If not institution, give street and number) McCready Memorial Hospital		9b. CITY, TOWN OR LOCATION OF DEATH Crisfield, MD		9c. COUNTY OF DEATH Somerset	
RESIDENCE OF DECEDENT							
10a. STATE Maryland		10b. COUNTY Somerset		10c. CITY, TOWN OR LOCATION Crisfield		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 2957 Byrdtown Road				10f. ZIP CODE 21817		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES W. W. II- U. S. Army		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) H. S. Graduate College (1-4 or 5+) - - -				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Barber		16b. KIND OF BUSINESS/INDUSTRY Owner- Barbershop	
17. FATHER'S NAME (First, Middle, Last) Unknown				18. MOTHER'S NAME (First, Middle, Maiden Surname) Unknown			
19a. INFORMANT'S NAME (Type/Print) Martha C. Gloriosos (Wife)				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2957 Byrdtown Road - Crisfield, MD 21817			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Meadowridge Memorial Park-5/10/96		20c. LOCATION — City or Town, State Elkridge, MD			
21. SIGNATURE OF FUNERAL SERVICE LICENSE Robert H. Bradshaw, Jr.				22. NAME AND ADDRESS OF FACILITY Bradshaw & Sons Funeral Home 306 W. Main St. - Crisfield, MD 21817			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Cor Pulmonale DUE TO (OR AS A CONSEQUENCE OF):							
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST b. COPD DUE TO (OR AS A CONSEQUENCE OF):							
c. DUE TO (OR AS A CONSEQUENCE OF):							
d. DUE TO (OR AS A CONSEQUENCE OF):							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO						24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input checked="" type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER [Signature]				29c. LICENSE NUMBER D29105		29d. DATE SIGNED (Month, Day, Year) 5/9/96	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Christon J. Huddleston, M.D. - 106 Milford St. - Salisbury, MD 21801							
31. DATE FILED (Month, Day, Year) MAY 13 1996				32. REGISTRAR'S SIGNATURE [Signature]			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



24 August 1954



96 15517

1 FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) RICHARD GRECO				2. DATE OF DEATH MONTH DAY YEAR May 1, 1996		3. TIME OF DEATH 2:30 a.m.	
4. SOCIAL SECURITY NUMBER 070-24-8331		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 65 YRS.		7. DATE OF BIRTH (Month, Day, Year) Feb. 10, 1931	
8. BIRTHPLACE (State or Foreign Country) New York				9. FACILITY NAME (If not institution, give street and number) Memorial Hospital			
10. CITY, TOWN OR LOCATION OF DEATH Cumberland				11. COUNTY OF DEATH Allegany			
12. STATE WV		13. COUNTY Hampshire		14. CITY, TOWN OR LOCATION Augusta		15. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
16. STREET AND NUMBER P.O. Box 306				17. ZIP CODE 26704		18. CITIZEN OF WHAT COUNTRY? U.S.A.	
19. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		20. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES Korean Conflict		21. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		22. RACE — American Indian, Black, White, etc. Specify: White	
23. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 4		24. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Engineer		25. KIND OF BUSINESS/INDUSTRY Electrical			
26. FATHER'S NAME (First, Middle, Last) Frank Greco				27. MOTHER'S NAME (First, Middle, Maiden Surname) Frances Genovese			
28. INFORMANT'S NAME (Type/Print) Margaret Greco				29. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. Box 306 Augusta, WV 26704			
30. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		31. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Cumberland Crematory May 1, 1996		32. DATE May 1, 1996		33. LOCATION — City or Town, State Cumberland, Md.	
34. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Robert C. Adams</i>				35. NAME AND ADDRESS OF FACILITY Merritt-Adams Funeral Home 404 Decatur St. Cumberland, Md. 21502			
36. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Hyperkalemia DUE TO (OR AS A CONSEQUENCE OF): b. Chronic Renal Failure DUE TO (OR AS A CONSEQUENCE OF): c. Ischemic Cardiomyopathy, Gangrene of Both legs, Diabetes Mellitus DUE TO (OR AS A CONSEQUENCE OF): d. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>							
37. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Ischemic Cardiomyopathy, Gangrene of Both legs, Diabetes Mellitus							
38. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		39. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO					
40. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		41. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
42. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		43. DATE OF INJURY (Month, Day, Year)		44. TIME OF INJURY M		45. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO	
46. DESCRIBE HOW INJURY OCCURRED		47. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		48. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
49. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
50. SIGNATURE AND TITLE OF CERTIFIER <i>N.A. Ranjithan</i>				51. LICENSE NUMBER D 19318		52. DATE SIGNED (Month, Day, Year) 5/1/96	
53. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Dr. N. Ranjithan-517 Oldtown Road-Cumberland, MD 21502							
54. DATE FILED (Month, Day, Year) MAY 02 1996		55. REGISTRAR'S SIGNATURE <i>Jahia Jackson-Rodell</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 687600 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

96 15518

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) FLOSSIE C. GARLITZ				2. DATE OF DEATH MONTH DAY YEAR May 4, 1996		3. TIME OF DEATH 3:00 p m	
4. SOCIAL SECURITY NUMBER 217-80-3950		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 74 YRS.		7. DATE OF BIRTH (Month, Day, Year) MAY 27 1921	
9a. FACILITY NAME (If not Institution, give street and number) ST. VINCENT NURSING CENTER				9b. CITY, TOWN OR LOCATION OF DEATH FROSTBURG		9c. COUNTY OF DEATH ALLEGANY	
10a. STATE MARYLAND		10b. COUNTY GARRETT		10c. CITY, TOWN OR LOCATION FROSTBURG		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 624 BEALL SCHOOL ROAD				10f. ZIP CODE 21532		10g. CITIZEN OF WHAT COUNTRY? U S A	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: WHITE	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 7		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) HOMEMAKER		16b. KIND OF BUSINESS/INDUSTRY OWN HOME			
17. FATHER'S NAME (First, Middle, Last) PETER MC KENZIE				18. MOTHER'S NAME (First, Middle, Maiden Surname) DORA CATON			
19a. INFORMANT'S NAME (Type/Print) MARGARET KENNEY				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) BEALL SCHOOL ROAD FROSTBURG, MARYLAND 21532			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) BLOCHER CEMETERY 5/8		20c. LOCATION — City or Town, State FROSTBURG, MARYLAND			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Douglas Haffer</i>				22. NAME AND ADDRESS OF FACILITY HAFER FROST MANSION FUNERAL HOME 58 FROST AVE. FROSTBURG, MARYLAND 21532			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → SUDDEN CARDIAC DEATH DUE TO (OR AS A CONSEQUENCE OF): CORONARY ARTERY DISEASE Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF):						Approximate Interval Between Onset and Death 10 MINUTES 5 YRS.	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. CEREBROVASCULAR ACCIDENT CHRONIC OBSTRUCTIVE LUNG DISEASE DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>						24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> OOA OTHER: <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Haffer</i>				29c. LICENSE NUMBER 26907		29d. DATE SIGNED (Month, Day, Year) MAY 6, 1996	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) HARJIT S. SIDHU 925 BISHOP WALSH ROAD CUMBERLAND, MARYLAND 21502							
31. DATE FILED (Month, Day, Year) MAY 07 1996				32. REGISTRAR'S SIGNATURE <i>Johi Davidson-Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

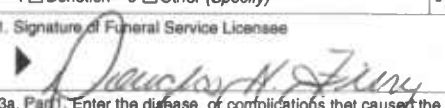
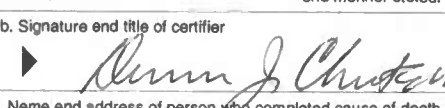
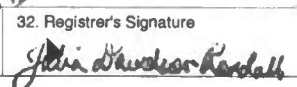
DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

96 15519

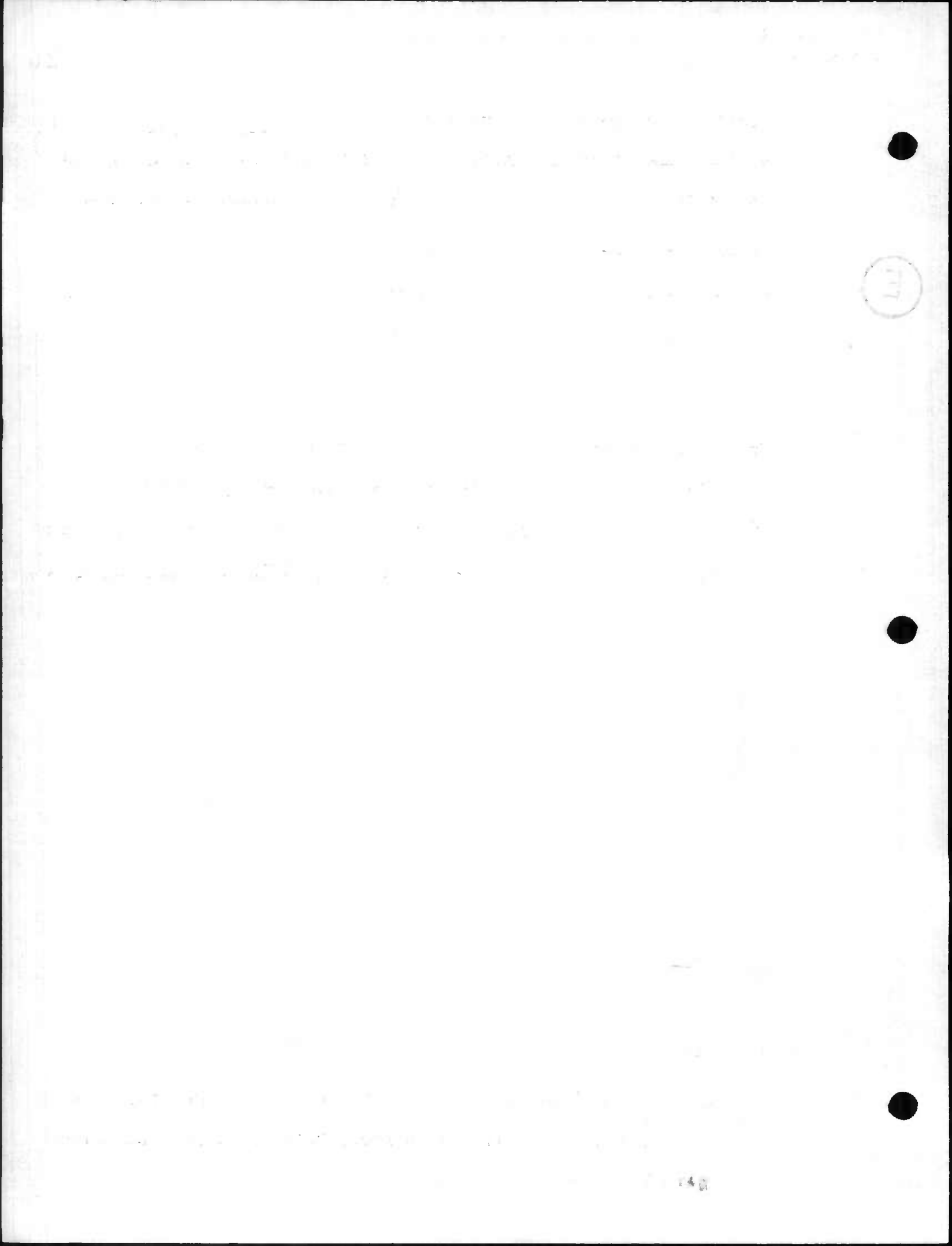
Physician /Medical Examiner		1. Decedent's Name (First, Middle, Last)		2. Date of Death		3. Time of Death	
		ELIZA GENTRY		MAY 12, 1996		0230 A	
Funeral Director		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Location of Death		4c. County of Death	
		Sacred Heart Hospital		Cumberland		Allegany	
		5. Social Security Number 216-22-6512	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 90 Yrs.	If Under 1 Year Months Days	8. Date of Birth (Month, Day, Year) Jan 5 1906	9. Birthplace (State or Foreign Country) Maryland
		Usual Residence of Decedent					
		10a. State Maryland	10b. County Allegany	10c. City, Town or Location Frostburg		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
		10e. Street and Number Frostburg Village Way		10f. Zip Code 21532		10g. Citizen of What Country? United States	
		11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
		14. Race - American Indian, Black, White, etc. Specify: White		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) Unknown College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker	
		16b. Kind of Business/Industry Home		17. Father's Name (First, Middle, Last) George Davis		18. Mother's Name (First, Middle, Maiden Surname) Mary Jones	
		19a. Informant's Name/Relationship (Type, Print) Frances Custer		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20802 Water Station Run Lonaconing, Md. 21539			
		20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Frostburg Memorial Park		20c. Location - City or Town, State 5-14-96 Frostburg, Md.	
		21. Signature of Funeral Service Licensee Wayne Boul		22. Name and Address of Facility Boal Funeral Home 41 Main St. Lonaconing, Md. 21539			
		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last a. Acute myocardial Infarction Due to (or as a consequence of): b. Coronary artery disease Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):					
		Approximate Interval Between Onset and Death one day 15 years					
		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Sudden sinus syndrome, Dilated Cardiomyopathy Hypertension					
		23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown					
		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No					
		25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M	
		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred			
		29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier H. Sidhu		29c. License number D 26907	
		29d. Data signed (Month, Day, Year) May 12, 1996		30. Name and address of person who completed cause of death (Item 23e) (Type, Print) HARJIT SIDHU, M.D. 925 BISHOP WALSH DRIVE CUMBERLAND, MD. 21502			
		31. Date filed (Month, Day, Year) MAY 15 1996		32. Registrar's Signature John Anderson-Randall			

(E)

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) EMILY Francesca HARRIS				2. Date of Death Month MAY Day 12 Year 1996		3. Time of Death 10:08 PM		
	4a. Facility Name (If not institution, give street and number) MALCOLM GROW HOSPITAL A.A.F.B				4b. City, Town, or Location of Death CAMP SPRINGS		4c. County of Death PRINCE GEORGES		
Funeral Director	5. Social Security Number 220-45-5737		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) Yrs. 8 10	8. Date of Birth (Month, Day, Year) September 2, 1995		9. Birthplace (State or Foreign Country) Germany		
	Usual Residence of Decedent								
To Be Completed by Funeral Director	10a. State Maryland		10b. County Prince Georges		10c. City, Town or Location Camp Springs		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
	10e. Street and Number 4365 Largo Lane				10f. Zip Code 20762		10g. Citizen of What Country? U.S.A.		
	11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 0 Years		College (1-4or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) N/A		16b. Kind of Business/Industry N/A		
	17. Father's Name (First, Middle, Last) Frank L. Harris				18. Mother's Name (First, Middle, Maiden Surname) Virginia A. Diaz				
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Frank L. Harris				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4365 Largo Lane Camp Springs, Md. 20762				
	20e. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Mt. Olivet Cemetery May 15, 1996		Date May 15, 1996		20c. Location - City or Town, State Frederick, Maryland		
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Douglas A. Fiery Funeral Home 1331 Eastern Blvd. North Hagerstown, Maryland 21742				
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) a. ASPHYXIA Due to (or as a consequence of): b. HANGING Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last								
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input type="checkbox"/> Natural <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year) FOUND 5-12-96		28b. Time of Death 9:00 PM		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred INFANT HANGED SELF ON BLIND'S CORDS	
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier 		29c. License number O.C.M.E		29d. Date signed (Month, Day, Year) MAY 13, 1996		28f. Location (Street and Number or Rural Route Number, City or Town, State) 4365 D'LARGO LANE ANDREW'S AIR FORCE BASE P.G. CO., MD	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dennis J Chute MD 111 Penn Street, Baltimore, Maryland 21201									
31. Date filed (Month, Day, Year) MAY 15 1996				32. Registrar's Signature 					

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



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1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Charles William Havens				2. DATE OF DEATH MONTH May DAY 12 YEAR 1996		3. TIME OF DEATH 3:30 P.M.	
4. SOCIAL SECURITY NUMBER 212-32-3162		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 92 YRS.		7. DATE OF BIRTH (Month, Day, Year) July 12 1903	
9a. FACILITY NAME (If not institution, give street and number) Asbury Methodist Village				9b. CITY, TOWN OR LOCATION OF DEATH Gaithersburg		9c. COUNTY OF DEATH Montgomery	
10a. STATE Maryland				10b. COUNTY Montgomery		10c. CITY, TOWN OR LOCATION Gaithersburg	
10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				10e. STREET AND NUMBER 201 Russell Avenue			
10f. ZIP CODE 20877				10g. CITIZEN OF WHAT COUNTRY? United States			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE YEAR OR DATES WWII		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: white	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (8-12) <input type="checkbox"/> College (1-4 or 5+) <input checked="" type="checkbox"/> 4		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) coach/athletic dir.		16b. KIND OF BUSINESS/INDUSTRY college			
17. FATHER'S NAME (First, Middle, Last) Charles W. Havens				18. MOTHER'S NAME (First, Middle, Maiden Surname) Mabel Healt			
19a. INFORMANT'S NAME (Type/Print) Charles W. Havens III				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20007 4641 Garfield Street, N.W., Washington, DC			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Westminster Cemetery 5/15/96 DATE		20c. LOCATION — City or Town, State Westminster, MD			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Kathleen Pires - Sweitzer				22. NAME AND ADDRESS OF FACILITY Pritts Funeral Home & Chapel 412 Washington Rd., Westminster, MD			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Congestive Heart Failure							
DUE TO (OR AS A CONSEQUENCE OF):							
b. Chronic obstructive lung Disease							
DUE TO (OR AS A CONSEQUENCE OF):							
c. _____							
DUE TO (OR AS A CONSEQUENCE OF):							
d. _____							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Renal failure							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA <input checked="" type="checkbox"/> OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER James B. Moore, Jr. MD				29c. LICENSE NUMBER 07231		29d. DATE SIGNED (Month, Day, Year) May 13 1996	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) James B. Moore, Jr. 207 Brookes Ave Gaithersburg MD 20877							
31. DATE FILED (Month, Day, Year) MAY 14 1996				32. REGISTRAR'S SIGNATURE John D. ...			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 15522

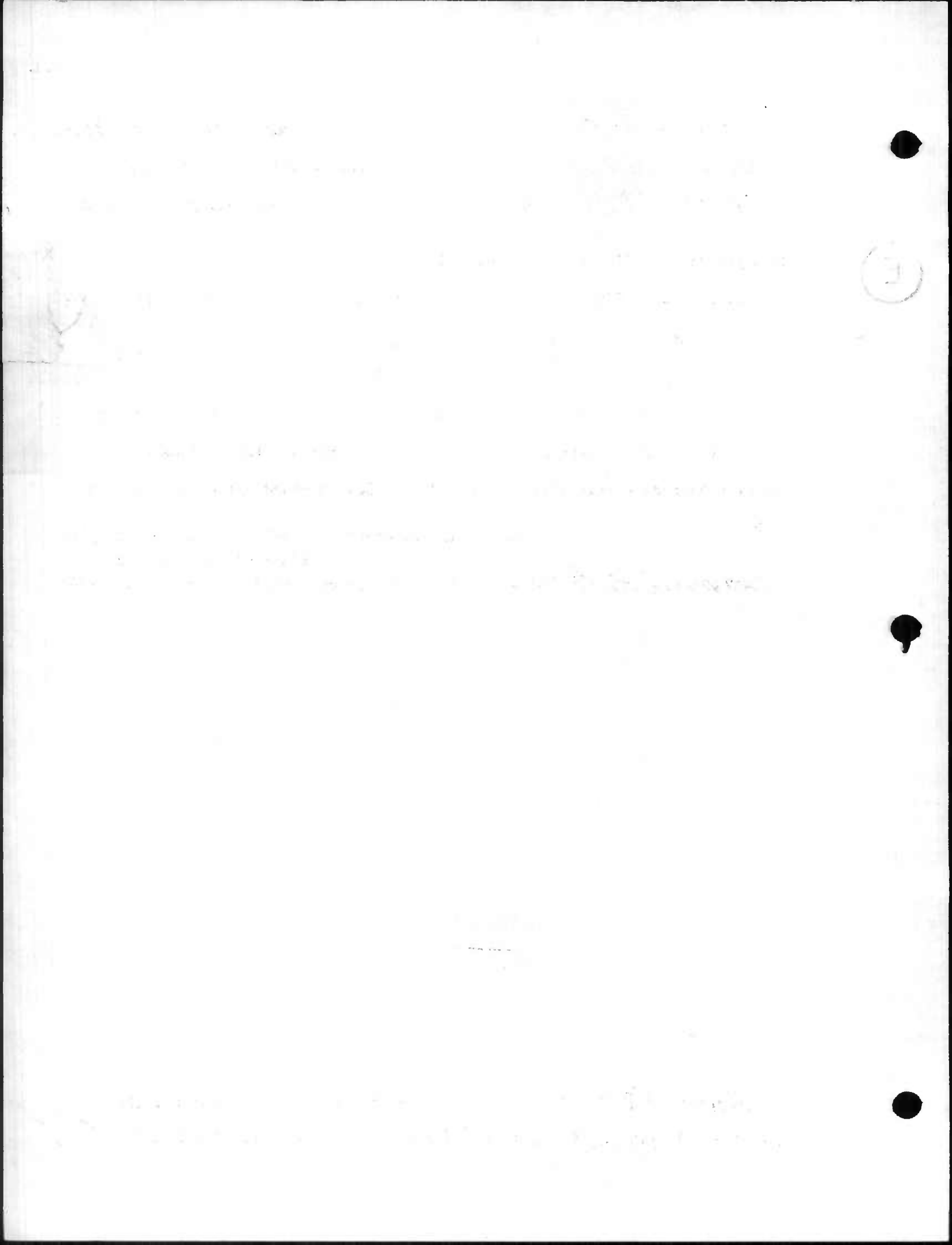
Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedant's Name (First, Middle, Last) HOMER DAVID HARRIS						2. Date of Death Month Day Year MAY 06 1996		3. Time of Death 05:56 A.M.	
	4a. Facility Name (If not institution, give street and number) Sacred Heart Hospital						4b. City, Town, or Location of Death Cumberland		4c. County of Death Allegany	
Funeral Director	5. Social Security Number 212-32-2782		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 68 Yrs.		8. Data of Birth (Month, Day, Year) Oct. 21, 1927		9. Birthplace (State or Foreign Country) Virginia	
	Usual Residence of Decedant									
To Be Completed by Funeral Director	10a. State Pennsylvania		10b. County Bedford		10c. City, Town or Location Bedford				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
	10e. Street and Number Rt. 3, box 585				10f. Zip Code 15522		10g. Citizen of What Country? United States			
To Be Completed by Physician/Medical Examiner	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 7 College (1-4 or 5+) -		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Farmer				16b. Kind of Business/Industry Dairy Farming			
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) Scott D. Harris						18. Mother's Name (First, Middle, Maiden Surname) Martha Irene Jenkins			
	19a. Informant's Name/Relationship (Type, Print) Betty Eckenrode Harris/wife				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rt. 3, Box 585/ Bedford, Pennsylvania 15522					
To Be Completed by Physician/Medical Examiner	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Rocky Hill Cemetery		Date 5-10		20c. Location - City or Town, State Woodsboro, Maryland			
	21. Signature of Funeral Service Licensee <i>Raymond Peterson</i>				22. Name and Address of Facility STAUFFER FUNERAL HOME 1621 Opossumtown Pike/ Frederick, Md. 21702					
To Be Completed by Physician/Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. MYOCARDIAL INFARCTION Due to (or as a consequence of): b. DIABETIC ARTERIO SCLEROTIC CARDIOVASCULAR DISEASE 10yrs Due to (or as a consequence of): c. Due to (or as a consequence of): d.									
	23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No									
To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. hypercholesterolemia follows below knee amputation from renal diabetic disease									
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No									
To Be Completed by Physician/Medical Examiner	26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)									
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
To Be Completed by Physician/Medical Examiner	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <i>Donald F. Manger</i>		29c. License number D09231		29d. Date signed (Month, Day, Year) MAY 06, 1996			
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DONALD F. MANGER 1442 HAZEN ROAD NE CUMBERLAND MD 21502									
State Registrar	31. Date filed (Month, Day, Year) MAY 14 1996		32. Registrar's Signature <i>Julia Shuckard Randall</i>							

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 15523

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Alice Mae Hurley				2. Date of Death Month Day Year May 7, 1996		3. Time of Death 2300	
	4a. Facility Name (If not institution, give street and number) PENINSULA REGIONAL MEDICAL CENTER				4b. City, Town, or Location of Death SALISBURY		4c. County of Death WICOMICO	
Funeral Director	5. Social Security Number 222-05-5310		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 80 Yrs.		8. Date of Birth (Month, Day, Year) 7-29-1915	
	9. Birthplace (State or Foreign Country) Virginia		10a. State Maryland		10b. County Worcester		10c. City, Town or Location Pocomoke City	
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		10e. Street and Number 806 Lynnhaven Drive		10f. Zip Code 21851		10g. Citizen of What Country? USA	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: white	
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 7 College (1-4or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Housewife		16b. Kind of Business/Industry		17. Father's Name (First, Middle, Last) Clarence E. Adkins	
	18. Mother's Name (First, Middle, Maiden Surname) Bonnie E. Davis		19a. Informant's Name/Relationship (Type, Print) Rosemary Payne		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2437 Stockton Rd., Pocomoke, Md. 21851		20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)	
Physician /Medical Examiner	20b. Place of Disposition (Name of cemetery, crematory or other place) Union Greenbackville Cemetery		20c. Date 5-10-96		20d. Location - City or Town, State Greenbackville, Va.		21. Signature of Funeral Service Licensee Joseph S. Melson	
	22. Name and Address of Facility Melson Funeral Home PO Box 64, Pocomoke, Md. 21851		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. Arteriosclerotic Heart Disease 30 yrs Due to (or as a consequence of): b. Arteriosclerosis Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		Approximate Interval Between Onset and Death 50 yrs		23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown	
Division of Vital Records, P.O. Box 68760,	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Pneumonia, congestive Heart Failure, essential Hypertension				24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		27. Manner of Death 1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)	
State Registrar	28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	
	28f. Location (Street and Number or Rural Route Number, City or Town, State)		29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier Dr. L. M. Evangelista MD		29c. License number 067670	
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	29d. Data signed (Month, Day, Year) 5/18/96		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. L. M. Evangelista		31. Data filed (Month, Day, Year) MAY 14 1996		32. Registrar's Signature Juba Davidson Randall	

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State of Maryland / Department of Health and Mental Hygiene

96 15524

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

CHELSEA

Elise

HUNGELMANN

2. Date of Death

Month

Day

Year

MAY 01, 1996

3. Time of Death

5:13 p.m.

Funeral
Director

4a. Facility Name (If not institution, give street and number)

THE JOHNS HOPKINS HOSPITAL

4b. City, Town, or Location of Death

BALTIMORE CITY

4c. County of Death

5. Social Security Number

219-45-0153

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)

11-1-1995

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Somerset

10c. City, Town or Location

Princess Anne

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

30558 Creek View Drive

10f. Zip Code

21853

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☒ Never Married 2 ☐ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever In U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

16b. Kind of Business/Industry

17. Father's Name (First, Middle, Last)

John Walter Hungelmann

18. Mother's Name (First, Middle, Maiden Surname)

Lisa Mia Milito

19a. Informant's Name/Relationship (Type, Print)

Lisa Hungelmann - (Mother)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

30558 Creek View Dr, Princess Anne, Md. 21853

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

First Baptist Cemetery 5-6-96 Pocomoke City, Md.

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Scott S. Melson

22. Name and Address of Facility

Melson Funeral Home
P.O. Box 64, Pocomoke City, Md. 21851

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. cardiac arrhythmia

Due to (or as a consequence of)

Approximate Interval Between Onset and Death

1h 20min

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. D.I.C.

Due to (or as a consequence of):

2h

c. hemorrhage

Due to (or as a consequence of):

2h

d. brain tumor (malignant)

unknown

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending Investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

P. Sampath

29c. License number

L3686

29d. Date signed (Month, Day, Year)

MAY 01, 1996

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

P. SAMPATH DEPT. NEUROSURGERY, JHH 600 WOLFE STREET BALTIMORE, MD 21287

31. Date filed (Month, Day, Year)

MAY 09 1996

32. Registrar's Signature

John Andrew Randall

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene
Certificate of Death

96 15525

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) ARDEN H. HAIGLEY					2. Date of Death Month MAY Day 11 , Year 1996		3. Time of Death 1517	
	4a. Facility Name (If not institution, give street and number) ATLANTIC GENERAL HOSPITAL					4b. City, Town, or Location of Death BERLIN		4c. County of Death WORCESTER	
Funeral Director	5. Social Security Number 218-26-2699		8. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 65 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) 6-24-30		9. Birthplace (State or Foreign Country) MD.
	Usual Residence of Decedent								
To Be Completed by Funeral Director	10e. State MD.	10b. County WORCESTER		10c. City, Town or Location BERLIN			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
	10e. Street and Number 12327 SINEPUXENT RD.				10f. Zip Code 21811		10g. Citizen of What Country? USA		
	11. Marital Status <input type="checkbox"/> Navar Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: WHITE		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) SALES MANAGER			16b. Kind of Business/Industry AUTOMOTIVE		
	17. Father's Name (First, Middle, Last) FRANK HAIGLEY					18. Mother's Name (First, Middle, Maiden Surname) RITA LINNEY			
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) ANDRES HAIGLEY					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12327 SINEPUXENT RD. BERLIN, MD., 21811			
	20e. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) SALISBURY CREMATORY		Data 5-13		20c. Location - City or Town, State SALISBURY, MD.	
	21. Signature of Funeral Service Licensee 					22. Name and Address of Facility ULLRICH FUNERAL HOME BERLIN, MD., 21811			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <div style="display: flex; justify-content: space-between;"> <div style="width: 80%;"> Immediate Cause (Final disease or condition resulting in death) a. congestive heart failure Due to (or as a consequence of): b. _____ Due to (or as a consequence of): c. _____ Due to (or as a consequence of): d. _____ </div> <div style="width: 15%; text-align: center;"> Approximate Interval Between Onset and Death Unknown </div> </div>								
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. diabetes mellitus								23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicidal <input type="checkbox"/> Homicidal <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined			28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how Injury occurred
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
29b. Signature and title of certifier  Physician					29c. License number H44283		29d. Date signed (Month, Day, Year) 5/11/96		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9733 HAZELWOOD DRIVE BERLIN, MD									
State Registrar	31. Date filed (Month, Day, Year) MAY 13 1996				32. Registrar's Signature 				

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 15526

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) William H. Hammond				2. Date of Death Month Day Year May 10, 1996		3. Time of Death 1236	
	4a. Facility Name (If not institution, give street and number) Calvert Memorial Hospital				4b. City, Town, or Location of Death Prince Frederick		4c. County of Death CALVERT	
Funeral Director	5. Social Security Number 212-10-8758		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 83 Yrs.		8. Date of Birth (Month, Day, Year) Dec 30 1912	
	9. Birthplace (State or Foreign Country) Maryland		10. Usual Residence of Decedent 10a. State: Maryland 10b. County: St Mary's 10c. City, Town or Location: Charlotte Hall 10d. Inside City Limits: <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	
To Be Completed by Funeral Director	13. Was Decedent of Hispanic Origin? (Specify Yes or No) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12): Unknown College (1-4 or 5+):		16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Unknown	
	17. Father's Name (First, Middle, Last) Unknown		18. Mother's Name (First, Middle, Maiden Surname) Unknown		19. Informant's Name/Relationship (Type, Print) Marcus Brookbank (Administrator)		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charlotte Hall VA Home Route @ Box 5 Charlotte Hall, MD	
Physician /Medical Examiner	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Maryland Veterans Cem, 5-15-96		20c. Location - City or Town, State Cheltenham, MD		21. Signature of Funeral Service Licensee M00173	
	22. Name and Address of Facility J.H. Eberwein Mortuary 4433 White Pls La White Plains, MD 20695		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Chronic Respiratory Failure Due to (or as a consequence of): b. Chronic Obstructive Lung Disease Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last		Approximate Interval Between Onset and Death 4 weeks		23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown	
To Be Completed by Physician/Medical Examiner	24. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No			
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify)			
To Be Completed by Physician/Medical Examiner	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
	28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.	
State Registrar	29b. Signature and title of certifier Dr. Anwar Munshi, M.D.		29c. License number D 19427		29d. Date signed (Month, Day, Year) 5/10/96		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Anwar Munshi, M.D., Prince Frederick, MD 20678	
	31. Date filed (Month, Day, Year) MAY 14 1996		32. Registrar's Signature John H. Randall					

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene
Certificate of Death

96 15527

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) STEPHEN JACKSON HINES						2. Date of Death Month Day Year APRIL 26, 1996		3. Time of Death 2225	
	4a. Facility Name (If not institution, give street and number) Sacred Heart Hospital						4b. City, Town, or Location of Death Cumberland		4c. County of Death Allegany	
Funeral Director	5. Social Security Number 235-72-0884		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 48 Yrs.		8. Date of Birth (Month, Day, Year) August 10, 1947		9. Birthplace (State or Foreign Country) West Virginia	
	Usual Residence of Decedent									
To Be Completed by Funeral Director	10a. State WV		10b. County Hampshire		10c. City, Town or Location Romney				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
	10e. Street and Number P. O. Box 167				10f. Zip Code 26757		10g. Citizen of What Country? U.S.A.			
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 7th College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Bar Tender			16b. Kind of Business/Industry Club		
	17. Father's Name (First, Middle, Last) James Edward Hines						18. Mother's Name (First, Middle, Maiden Surname) Grace V. Loy			
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Betty J. Gordon						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P. O. Box 75, Romney, WV 26757			
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Ebenezer Cemetery		20c. Location - City or Town, State Romney, WV		20d. Date April 30, 1996	
	21. Signature of Funeral Service Licensee 						22. Name and Address of Facility Shaffer Funeral Home, Inc. 230 East Main St., Romney, WV 26757			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <div style="display: flex; justify-content: space-between;"> <div style="width: 80%;"> <p>e. Respiratory failure with sepsis Due to (or as a consequence of):</p> <p>b. Cancer of lung with wide spread Metastasis Due to (or as a consequence of):</p> <p>c. spread Metastasis Due to (or as a consequence of):</p> <p>d. </p> </div> <div style="width: 15%; text-align: center;"> <p>Approximate Interval Between Onset and Death</p> <p>6 days</p> <p>4 months</p> </div> </div>									
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.									
23b. Did tobacco use contribute to the cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown										
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No						24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No										
26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)										
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how Injury occurred		
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)						28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.										
29b. Signature and title of certifier 						29c. License number 0-17526		29d. Date signed (Month, Day, Year) APRIL 27, 1996		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JOHN MEHANNA M.D. 909 B SETON DRIVE CUMBERLAND, MD. 21502										
31. Date filed (Month, Day, Year) MAY 02 1996										
32. Registrar's Signature 										

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 15528

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) RICHARD JAMES HESS				2. Date of Death Month MAY Day 5 Year 1996		3. Time of Death 1523 PM	
	4a. Facility Name (If not institution, give street and number) 635-B OLD FROSTBURG ROAD				4b. City, Town, or Location of Death FROSTBURG		4c. County of Death GARRETT	
Funeral Director	5. Social Security Number 215 88 0312		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 32 Yrs.		8. Date of Birth (Month, Day, Year) MARCH 27, 1964	
	9. Birthplace (State or Foreign Country) MARYLAND		10. Usual Residence of Decedent 10a. State MARYLAND 10b. County ALLEGANY 10c. City, Town or Location FROSTBURG		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
10e. Street and Number 101 OAK STREET		10f. Zip Code 21532		10g. Citizen of What Country? U.S.				
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: WHITE		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) 		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) LABORER		16b. Kind of Business/Industry CONSTRUCTION				
17. Father's Name (First, Middle, Last) JOSEPH B. HESS				18. Mother's Name (First, Middle, Maiden Surname) MARY (LANCASTER) HESS				
19a. Informant's Name/Relationship (Type, Print) ROBERT M. HESS /BROTHER				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 39 1/2 UHL ST., FROSTBURG, MD 21532				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) ST. MICHAEL'S CEMETERY 5/9/96		20c. Location - City or Town, State FROSTBURG, MD 21532				
21. Signature of Funeral Service licensee <i>Mailey M. Sowers</i>		22. Name and Address of Facility SOWERS FUNERAL HOME, P.A. 60 W. MAIN ST., FROSTBURG, MD 21532						
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <i>Gun shot wound of Head</i> Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
						24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
						24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year) 05-05-96		28b. Time of Injury 1605 M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Residence		28d. Describe how injury occurred Subject shot self				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <i>[Signature]</i>		29c. License number O.C.M.E		29d. Date signed (Month, Day, Year) MAY 6, 1996		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) David R Fowler 111 Penn Street, Baltimore, Maryland 21201								
31. Date filed (Month, Day, Year) MAY 08 1996		32. Registrar's Signature <i>[Signature]</i>						

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 15529

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) ELISHA CLAY HUFF				2. Date of Death Month Day Year MAY 7 1996		3. Time of Death 12:05 PM	
	4a. Facility Name (If not Institution, give street and number) SACRED HEART HOSPITAL				4b. City, Town, or Location of Death CUMBERLAND		4c. County of Death ALLEGANY	
Funeral Director	5. Social Security Number 219-14-5426		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 72 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Mar. 15, 1924	
	9. Birthplace (State or Foreign Country) MARYLAND							
To Be Completed by Funeral Director	Usual Residence of Decedent							
	10a. State MD		10b. County ALLEGANY		10c. City, Town or Location CUMBERLAND			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
	10e. Street and Number 506 LINDEN STREET				10f. Zip Code 21502		10g. Citizen of What Country? U.S.A.	
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: '43-'45		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: WHITE	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 Collage (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) SALESMAN			16b. Kind of Business/Industry RETAIL STORE		
	17. Father's Name (First, Middle, Last) CLAUDE HUFF				18. Mother's Name (First, Middle, Maiden Surname) CATHERINE FISHER			
	19a. Informant's Name/Relationship (Type, Print) SANDRA THOMAS				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 502 ROSE HILL AVENUE - CUMBERLAND, MD 21502			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) M.S.V.C.-ROCKY GAP		Data 5/10/96		20c. Location - City or Town, State FLINTSTONE, MD	
	21. Signature of Funeral Service Licensee Sherry G. Upchurch				22. Name and Address of Facility GEORGE-UPCHURCH FUNERAL HOME, P.A. 202 GREENE ST., CUMBERLAND, MD 21502			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. SEPTIC SHOCK Due to (or as a consequence of): b. HEPATIC ABSCESS Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown								
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. APLASTIC ANEMIA PANCREATITIS, HYPERTENSION								
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)								
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		
28a. Place of injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how injury occurred						
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
29b. Signature and title of certifier Huff				29c. License number D26907		29d. Date signed (Month, Day, Year) MAY 7, 1996		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hargit Sedha M.D. 925 Bishop Walsh Road Cumberland, MD 21502.								
31. Date filed (Month, Day, Year) MAY 09 1996				32. Registrar's Signature Jane [Signature]				

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 15530

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

ALICE VIRGINIA HOUSE

2. Date of Death
Month Day Year

MAY 3, 1996

3. Time of Death

1735

4a. Facility Name (If not institution, give street and number)

Sacred Heart Hospital

4b. City, Town, or Location of Death

Cumberland

4c. County of Death

Allegheny

5. Social Security Number

232-26-0524

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

75

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth
(Month, Day, Year)

Oct. 2, 1920

9. Birthplace (State or Foreign Country)

W.V.

Usual Residence of Decedent

10a. State

Maryland

10b. County

Allegheny

10c. City, Town or Location

Lonaconing

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

23 Douglas Avenue

10f. Zip Code

21539

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

8

College (1-4 or 5+)

0

16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)

Labor

16b. Kind of Business/Industry

Tire Co.

17. Father's Name (First, Middle, Last)

Elijah S. Parish

18. Mother's Name (First, Middle, Maiden Summa)

Mary A. Martin

19a. Informant's Name/Relationship (Type, Print)

Dorothy Rayner-Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Box 37, Midland, Md. 21542

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Oak Hill Cemetery May 6, 1996 Lonaconing, Md.

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Eichhom-McKenzie Funeral Home
Lonaconing, Md. 21539

23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Cancer of the lung (Pigra)
Stage IV

Approximate Interval Between Onset and Death

15 months

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

a. Due to (or as a consequence of):
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

COPD and Emphysema. Congestive heart failure, Advanced Cancer lung with distant metastasis

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined28a. Date of Injury
(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier
(Check only one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D 14464

29d. Date signed (Month, Day, Year)

MAY 6, 1996

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Sikander Sandhir 48 Tarn Terrace Frostburg, MD 21532

31. Date filed (Month, Day, Year)

MAY 09 1996

32. Registrar's Signature

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 24a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

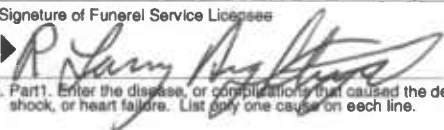

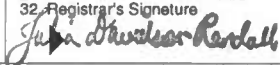
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 15531

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) ALFONSAS JAKIMONIS		2. Date of Death Month MAY Day 10 Year 1996		3. Time of Death 2:20 PM
	4a. Facility Name (If not Institution, give street and number) 8405 UPPERHILL RD.		4b. City, Town, or Location of Death WESTOVER		4c. County of Death SOMERSET
Funeral Director	5. Social Security Number 032-20-1882	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 91 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
	8. Date of Birth (Month, Day, Year) 10/10/1904		9. Birthplace (State or Foreign Country) LITHUNIA		
To Be Completed by Funeral Director	Usual Residence of Decedent				
	10a. State MD.	10b. County somerset	10c. City, Town or Location westover		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
	10e. Street and Number 8405 UPPERHILL RD.		10f. Zip Code 21871		10g. Citizen of What Country? USA
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:
	14. Race - American Indian, Black, White, etc. Specify: WHITE				
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10 College (1-4or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) FARMER		16b. Kind of Business/Industry AGRICULTURE
	17. Father's Name (First, Middle, Last) ANTHONY JAKIMONIS		18. Mother's Name (First, Middle, Maiden Surname) CAROL		
	19a. Informant's Name/Relationship (Type, Print) HELEN JAKIMONIS		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8405 UPPERHILL RD., WESTOVER, MD. 21871		
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) EVERGREEN MEMORIAL GARDENS		20c. Location - City or Town, State FINKSBURG, MD.
	21. Signature of Funeral Service Licensee 		22. Name and Address of Facility FLETCHER FUNERAL HOME 254 E. MAIN ST., WESTMINSTER, MD. 21157		
Physician /Medical Examiner	23a. Part I. Enter the disease, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.				Approximate Interval Between Onset and Death
	Immediate Cause (Final disease or condition resulting in death) e. Congestive Heart Failure Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.				12 Mo
To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown
					24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
					24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
	28d. Describe how Injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		
	28f. Location (Street and Number or Rural Route Number, City or Town, State)				
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				
State Registrar	29b. Signature and title of certifier 		29c. License number D24872		29d. Date signed (Month, Day, Year) 5/13/96
	30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Dr. Paul R. Fleury 305 Tenth St. Pocomoke City, Md.				
	31. Date filed (Month, Day, Year) MAY 14 1996		32. Registrar's Signature 		

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 15532

Certificate of Death

Reg. No.

Physician
/Medical
ExaminerFuneral
Director

1. Decedent's Name (First, Middle, Last)

Paul Vernon KELLER

2. Date of Death

May 10 1996 14:27

3. Time of Death

4a. Facility Name (If not institution, give street and number)

Washington County Hospital

4b. City, Town, or Location of Death

Hagerstown

4c. County of Death

Washington

5. Social Security Number

219-12-2311

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

76 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Dec. 29, 1919

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Washington

10c. City, Town or Location

Hagerstown

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

17406 Lexington Avenue

10f. Zip Code

21740

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give

Year or Dates: W.W.II

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: white

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

0-12

College (1-4 or 5+)

0

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

owner

16b. Kind of Business/Industry

electric

17. Father's Name (First, Middle, Last)

Clarence N. Keller

18. Mother's Name (First, Middle, Maiden Summa)

Nellie Reynold Keller

19a. Informant's Name/Relationship (Type, Print)

Mrs. Jane E. Keller

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

17406 Lexington Avenue, Hagerstown, Maryland 21740

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Rest Haven Cemetery

Date

5-14-96 Hagerstown, Maryland

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Scott Minnich

22. Name and Address of Facility

Minnich Funeral Home
415 East Wilson Blvd., Hagerstown, Maryland 21740

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Terminal Respiratory Failure

Approximate Interval Between Onset and Death

two weeks

Due to (or as a consequence of):

Chronic Obstructive pulmonary disease

15 years

Due to (or as a consequence of):

Bronchospasm, steroid dependent

15 years

Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Protein losing nephropathy of unknown cause

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 5 ☐ Pending investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Robert Buell Personal Physician

29c. License number

D04359

29d. Date signed (Month, Day, Year)

May 11 1996

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Robert Buell 1459 Potomac Ave. Hagerstown

31. Date filed (Month, Day, Year)

MAY 13 1996

32. Registrar's Signature

John Anderson

State Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Amended -#1 - SR. - G.A.P. - 5/16/96

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 15533

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) CHARLES Edward KIAH ^{SR.} SENIOR				2. Date of Death Month MAY Day 12 Year 1996		3. Time of Death 10:00 AM	
	4a. Facility Name (If not institution, give street and number) Dorchester General Hospital				4b. City, Town, or Location of Death Cambridge		4c. County of Death Dorchester	
Funeral Director	5. Social Security Number 218-20-7441		8. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 87 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) August 20, 1908	9. Birthplace (State or Foreign Country) Maryland
	Usual Residence of Decedent							
To Be Completed by Funeral Director	10a. State Maryland		10b. County Dorchester		10c. City, Town or Location Cambridge		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	10e. Street and Number 2363 Church Creek Road				10f. Zip Code 21613		10g. Citizen of What Country? U.S.A.	
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - if Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 4		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Pastor		16b. Kind of Business/Industry Methodist Church			
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) Charles Franklin Kiah				18. Mother's Name (First, Middle, Maiden Surname) Margaret Montgomery			
	19a. Informant's Name/Relationship (Type, Print) Regina Melu Kiah (wife)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2363 Church Creek Road Cambridge, MD. 21613			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Rock Cemetery		20c. Location - City or Town, State 5/18/96 Cambridge, MD.		20d. Date	
	21. Signature of Funeral Service Licensee Janelle C. Henry		22. Name and Address of Facility HENRY FUNERAL HOME 510 Washington St. Cambridge, Maryland					
Physician /Medical Examiner	23a. Pertinent. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. MYOCARDIAL INFARCTION Due to (or as a consequence of): b. HYPERTENSION Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							Approximate Interval Between Onset and Death 1 HOUR 20 YEARS
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ORGANIC BRAIN SYNDROME TRANSITIONAL CELL CARCINOMA - BLADDER							23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
	26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							24b. Were autopsy findings available prior to completion of cause of death? YES <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Medical Certification: To Be Completed by Physician/Medical Examiner	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier Michael A. Moskewicz MD.		29c. License number D-16609		29d. Date signed (Month, Day, Year) May 13, 1996	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MICHAEL A. MOSKEWICZ M.D. 503 BURN ST. CAMBRIDGE MD 21613							
State Registrar	31. Date filed (Month, Day, Year) MAY 15 1996		32. Registrar's Signature John Davidson-Randall					

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

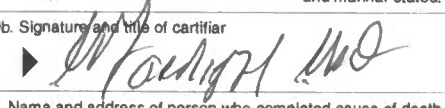
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene
Certificate of Death

96 15534

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Phyllis Elizabeth KRETZER					2. Date of Death Month May Day 12 Year 1996			3. Time of Death 1030 am	
	4a. Facility Name (If not institution, give street and number) 64 1/2 West Franklin Street					4b. City, Town, or Location of Death Hagerstown			4c. County of Death Washington	
Funeral Director	5. Social Security Number 217-80-2169		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 71 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Dec. 31, 1924		9. Birthplace (State or Foreign Country) West Virginia	
	Usual Residence of Decedent									
10a. State Maryland		10b. County Washington		10c. City, Town or Location Hagerstown					10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10e. Street and Number 64 1/2 West Franklin Street					10f. Zip Code 21740			10g. Citizen of What Country? USA		
11. Marital Status <input type="checkbox"/> Navar Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 6 College (1-4or 5+)					16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Housewife			16b. Kind of Business/Industry Home		
17. Father's Name (First, Middle, Last) Charles Washington Dillow						18. Mother's Name (First, Middle, Maiden Summa) Bertie May Penwell				
19a. Informant's Name/Relationship (Type, Print) Larry Jackson					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 15520 Clear Spring Rd. Williamsport, MD 21795					
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Mt. View Cemetery		Date May 15, 1996		20c. Location - City or Town, State Sharpsburg, Maryland		
21. Signature of Funeral Service Licensee 					22. Name and Address of Facility Osborne Funeral Home 425 S. Conococheague St. Williamsport, MD 21795					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <div style="display: flex; justify-content: space-between;"> <div style="width: 70%;"> <p>Immediate Cause (Final disease or condition resulting in death) Aorta Myocardial Infarction</p> <p>Due to (or as a consequence of): Arteriosclerosis of Aorta</p> <p>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last</p> <p>c. Due to (or as a consequence of):</p> <p>d. Due to (or as a consequence of):</p> </div> <div style="width: 25%; text-align: center;"> <p>Approximate Interval Between Onset and Death 2 hrs</p> </div> </div>										
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
								24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide			28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)					28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										
29b. Signature and title of certifier 					29c. License number DR 6041			29d. Date signed (Month, Day, Year) 5-14-96		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) E.R. LARSEN 362 S. W. Cleveland Hagerstown, MD 21740										
31. Date filed (Month, Day, Year) MAY 14 1996			32. Registrar's Signature 							

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0020
 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
 Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

96 15535

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Mabel Elizabeth Keenan				2. DATE OF DEATH MONTH DAY YEAR May 8 1996		3. TIME OF DEATH 2250 P M	
4. SOCIAL SECURITY NUMBER 225-10-3593		5. SEX 1 M 2 F		6. AGE (In yrs. last birthday) 76 YRS.		7. DATE OF BIRTH (Month, Day, Year) March 2, 1920	
8. BIRTHPLACE (State or Foreign Country) North Carolina				9. FACILITY NAME (If not institution, give street and number) Medpointe Continuing Care Center			
10. CITY, TOWN OR LOCATION OF DEATH Elkton				11. COUNTY OF DEATH Cecil			
12. RESIDENCE OF DECEDENT				13. CITIZEN OF WHAT COUNTRY?			
10a. STATE Maryland		10b. COUNTY Cecil		10c. CITY, TOWN OR LOCATION Elkton		10d. INSIDE CITY LIMITS? 1 X YES 2 NO	
10e. STREET AND NUMBER 1 Price Drive				10f. ZIP CODE 21921		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS 3 X Widowed		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 YES 2 NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) 11				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Electronics Inspector		16b. KIND OF BUSINESS/INDUSTRY Electronics	
17. FATHER'S NAME (First, Middle, Last) Richard Phillips				18. MOTHER'S NAME (First, Middle, Maiden Surname) Emma Woodruff			
19a. INFORMANT'S NAME (Type/Print) Patricia A. Benner				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4 Shady Lane, Lincoln University, PA 19352			
20a. METHOD OF DISPOSITION 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Glenwood Memorial Gardens 5-13 96		20c. LOCATION — City or Town, State Broomall, PA			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Donned S. Hicks</i>				22. NAME AND ADDRESS OF FACILITY Hicks Home for Funerals, P.A. 103 W. Stockton St. Elkton, MD 21921-5521			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Coronary Artery Accident with Right Hemiparesis							
DUE TO (OR AS A CONSEQUENCE OF):							
b. Hypertension							
DUE TO (OR AS A CONSEQUENCE OF):							
c. DUE TO (OR AS A CONSEQUENCE OF):							
d. DUE TO (OR AS A CONSEQUENCE OF):							
Approximate Interval Between Onset and Death 12 yrs. unknown							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 X Natural 2 Accident 3 Suicide 4 Homicide 5 Pending Investigation 6 Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 YES 2 NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 X CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Monte Makous, M.D.</i>				29c. LICENSE NUMBER D-44783		29d. DATE SIGNED (Month, Day, Year) 5-9-96	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Monte Makous, M.D. 111 West High Street, Elkton, Maryland 21921							
31. DATE FILED (Month, Day, Year) MAY 10 1996				32. REGISTRAR'S SIGNATURE <i>John A. H. Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 15536

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) EILEEN MAY LIPSON				2. Date of Death Month May Day 13th Year 1996		3. Time of Death 1625	
	4a. Facility Name (If not institution, give street and number) Washington County Hospital				4b. City, Town, or Location of Death Hagerstown		4c. County of Death Washington	
Funeral Director	5. Social Security Number 215-01-6019		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 82 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) May 30, 1913	9. Birthplace (State or Foreign Country) Maryland
	Usual Residence of Decedent							
To Be Completed by Funeral Director	10a. State Maryland		10b. County Washington		10c. City, Town or Location Williamsport		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	10a. Street and Number 16505 Virginia Avenue				10f. Zip Code 21795		10g. Citizen of What Country? U.S.A.	
To Be Completed by Physician/Medical Examiner	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 2 years College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Nurse		16b. Kind of Business/Industry Hospital			
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) Unknown Rankin				18. Mother's Name (First, Middle, Maiden Surname) Sarah Coyne			
	19a. Informant's Name/Relationship (Type, Print) Martin Tashgy / Son				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20206 Mahogany Drive Hagerstown, Maryland 21742			
To Be Completed by Physician/Medical Examiner	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Smithsburg Crematory		Date May 15, 1996		20c. Location - City or Town, State Smithsburg, Maryland	
	21. Signature of Funeral Service Licensee <i>[Signature]</i>				22. Name and Address of Facility Douglas A. Fiery Funeral Home 1331 Eastern Blvd. N. Hagerstown, Maryland 21742			
To Be Completed by Physician/Medical Examiner	23a. Part I: Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. RENAL INSUFFICIENCY - FAILURE Due to (or as a consequence of): b. RIGHT LOWER LOBE PNEUMONIA Due to (or as a consequence of): c. ATRIAL FIBRILLATION Due to (or as a consequence of): d. PERIPHERAL VASCULAR DISEASE							Approximate Interval Between Onset and Death 1 wk.
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. CORONARY ARTERY DISEASE							23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown
To Be Completed by Physician/Medical Examiner	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
To Be Completed by Physician/Medical Examiner	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how injury occurred					
To Be Completed by Physician/Medical Examiner	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
	29b. Signature and title of certifier <i>[Signature]</i>				29c. License number D22043		29d. Date signed (Month, Day, Year) 5/14/96	
To Be Completed by Physician/Medical Examiner	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1799 Howell RD HAGERSTOWN MD 21740.							
	31. Date filed (Month, Day, Year) MAY 15 1996		32. Registrar's Signature <i>[Signature]</i>					

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



Amend # 1 Wash Co. Health Dept LB May 17 1996 98 175537

1. FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Emma Elizabeth Elizabeth LAYMAN				2. DATE OF DEATH MONTH DAY YEAR May 15, 1996		3. TIME OF DEATH 3:00 A M	
4. SOCIAL SECURITY NUMBER 214-09-7169		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 99 YRS.		7. DATE OF BIRTH (Month, Day, Year) Aug. 25, 1896	
8. BIRTHPLACE (State or Foreign Country) W. Virginia		9a. FACILITY NAME (If not institution, give street and number) Ravenwood Lutheran Village		9b. CITY, TOWN OR LOCATION OF DEATH Hagerstown		9c. COUNTY OF DEATH Washington	
10a. STATE Maryland		10b. COUNTY Washington		10c. CITY, TOWN OR LOCATION Hagerstown		10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER 1183 Luther Drive				10f. ZIP CODE 21740		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR RATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 0				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Manager		16b. KIND OF BUSINESS/INDUSTRY Retail Sales	
17. FATHER'S NAME (First, Middle, Last) James Jefferson Via				18. MOTHER'S NAME (First, Middle, Maiden Surname) Electra Jane Mills			
19a. INFORMANT'S NAME (Type/Print) Robert Downin III Grandson				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. Box 310 Falling Waters, W.Va. 25419			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Rest Haven Cemetery 5-17-96		20c. LOCATION — City or Town, State Hagerstown, Maryland		20d. DATE	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Scott M. Munn</i>				22. NAME AND ADDRESS OF FACILITY Minnich Funeral Home 415 E. Wilson Blvd. Hagerstown, Md. 21740			
23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) →		a. <i>Metastatic carcinoma to lungs</i> DUE TO (OR AS A CONSEQUENCE OF):				Approximate Interval Between Onset and Death 9 months	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST		b. <i>Renal cell carcinoma</i> DUE TO (OR AS A CONSEQUENCE OF):				5 years	
		c. DUE TO (OR AS A CONSEQUENCE OF):					
		d. DUE TO (OR AS A CONSEQUENCE OF):					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Hypertensive heart disease</i> <i>Chronic kidney disease</i>							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO					
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, term, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Edson Moody</i>				29c. LICENSE NUMBER 007857		29d. DATE SIGNED (Month, Day, Year) 5/16/96	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Dr. Edson Moody 1190 Mt. Aetna Rd Hagerstown, MD 21740							
31. DATE FILED (Month, Day, Year) MAY 17 1996				32. REGISTRAR'S SIGNATURE <i>Jebia Anderson-Russell</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 15538

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

EMILY M. LEATHERMAN

2. Date of Death

Month Day Year
MAY 10, 1996

3. Time of Death

8:08 AM.

Funeral
Director

4a. Facility Name (If not institution, give street and number)

960 Uniontown Road

4b. City, Town, or Location of Death

Westminister

4c. County of Death

Carroll

5. Social Security Number

218-07-3838

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

85 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
February 27, 1911

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

MD

10b. County

Carroll

10c. City, Town or Location

960 Uniontown Road

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

960 Uniontown Road

10f. Zip Code

21158

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

2

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

School Teacher

16b. Kind of Business/Industry

Education

17. Father's Name (First, Middle, Last)

James William Mason

18. Mother's Name (First, Middle, Maiden Surname)

Orintha Hannah Exline

19a. Informant's Name/Relationship (Type, Print)

Paul W. Leatherman

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

18812 Preston RD Hagerstown, MD 21742

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

St. Peter's Catholic Cemetery

Date

5/13/96

20c. Location - City or Town, State

Hancock, MD 21750

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Grove Funeral Home

P.O. Box 368

Hancock, MD

21750

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. congestive Heart Failure

Approximate Interval Between Onset and Death

6 mos

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):
Atrial Fibrillation

6 mos

c. Due to (or as a consequence of):
ischemic Bowel

6 mos

d. Due to (or as a consequence of):
Massive lower GI Bleeding

6 mos

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

malnutrition, pneumonia
respiratory Failure, Non
insulin dependent Diabetes

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☒ Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Kaufman MD

29c. License number

D38915

29d. Date signed (Month, Day, Year)

5/10/96

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

FRETSI

295

Stoner Rd westminister

State
Registrar

31. Date filed (Month, Day, Year)

MAY 23 1996

32. Registrar's Signature

Julia Anderson Randall

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 23e show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 15539

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Kenneth Eugene MANN						2. Date of Death Month Day Year May 10, 1996		3. Time of Death 1:00 AM	
	4a. Facility Name (If not institution, give street and number) 17615 Meadowood Drive						4b. City, Town, or Location of Death Hagerstown		4c. County of Death Washington	
Funeral Director	5. Social Security Number 219-46-2159		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 50 Yrs.		8. Date of Birth (Month, Day, Year) Oct. 16, 1945		9. Birthplace (State or Foreign Country) Maryland	
	Usual Residence of Decedent									
10a. State Maryland		10b. County Washington		10c. City, Town or Location Hagerstown				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
10e. Street and Number 17615 Meadowood Drive				10f. Zip Code 21740		10g. Citizen of What Country? USA				
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: white		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) 8				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) principal			16b. Kind of Business/Industry schools			
17. Father's Name (First, Middle, Last) Carl M. Mann						18. Mother's Name (First, Middle, Maiden Surname) Helen G. Wiegand				
19a. Informant's Name/Relationship (Type, Print) Diane Mann						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 17615 Meadowood Dr., Hagerstown, Md. 21740				
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Cedar Lawn Memorial Park		20c. Date 5-13-96		20d. Location - City or Town, State Hagerstown, Maryland			
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility MINNICH FUNERAL HOME 415 E. Wilson Blvd., Hagerstown, Md. 21740						
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. <u>Carcinoma of Colon</u> Due to (or as a consequence of): b. _____ Due to (or as a consequence of): c. _____ Due to (or as a consequence of): d. _____ Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last										Approximate Interval Between Onset and Death 25 months
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No										24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)						
27. Manner of Death 1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how Injury occurred
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier 		29c. License number 223623		29d. Date signed (Month, Day, Year) 5/10/96		
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Frederick H. Kass 411 W 1799 Howell Rd Hagerstown Md										
31. Date filed (Month, Day, Year) MAY 13 1996				32. Registrar's Signature 						

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

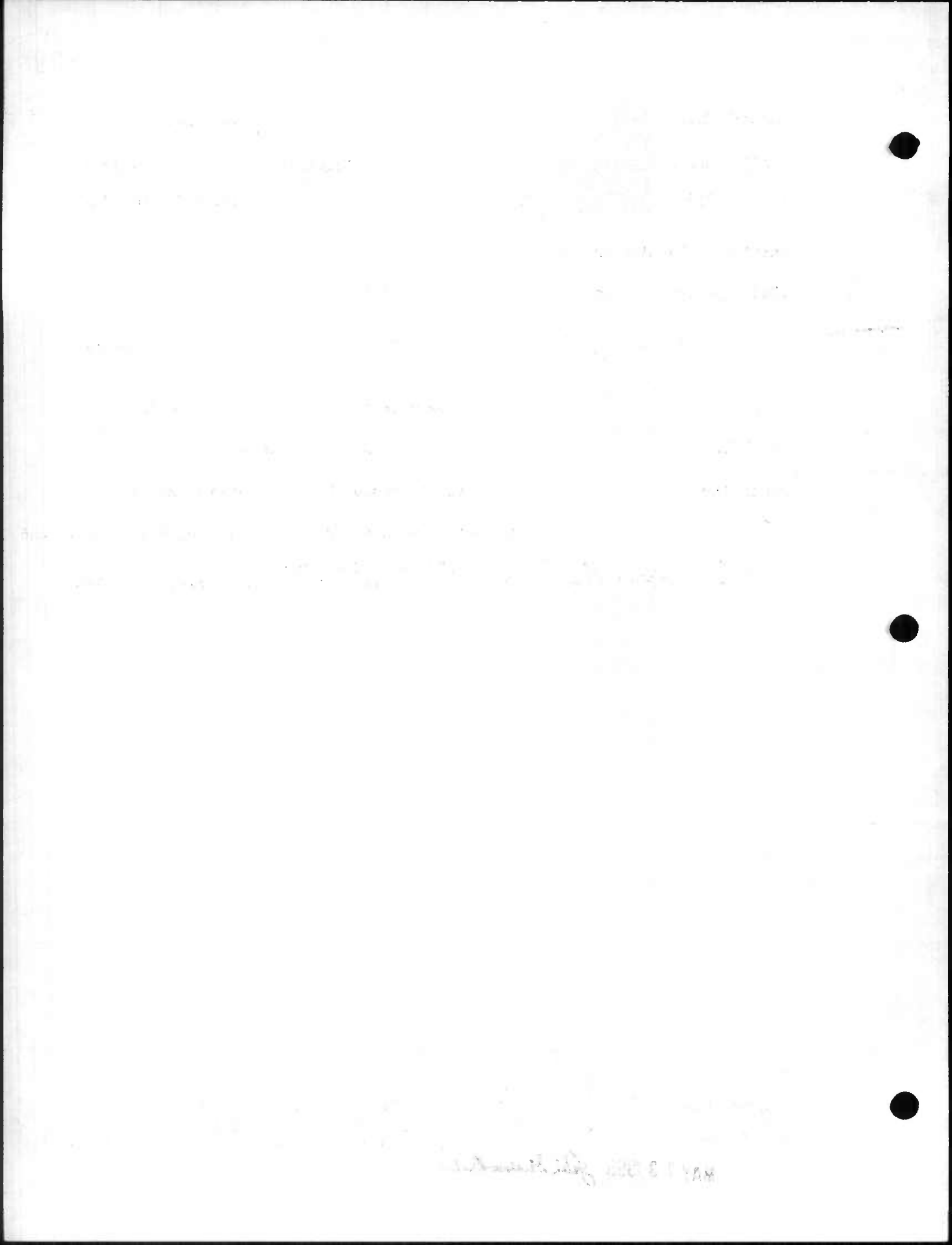
Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 15540

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

JOHN MILLER

MITCHELL

2. Date of Death

Month Day Year
MAY 12, 1996

3. Time of Death

7:04 PM

4e. Facility Name (If not institution, give street and number)

THE JOHNS HOPKINS HOSPITAL

4b. City, Town, or Location of Death

BALTIMORE CITY

4c. County of Death

Baltimore

Funeral
Director

5. Social Security Number

592-16-3289

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

27 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Feb. 12, 1969

9. Birthplace (State or Foreign Country)

Massachusetts

Usual Residence of Decedent

10e. State

Maryland

10b. County

Washington

10c. City, Town or Location

Hagerstown

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

20827 Emerald Drive

10f. Zip Code

21742

10g. Citizen of What Country?

USA

11. Marital Status

1 ☒ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: white

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
12College (1-4 or 5+)
0

16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

none

16b. Kind of Business/Industry

- - -

17. Father's Name (First, Middle, Last)

unknown

18. Mother's Name (First, Middle, Maiden Surname)

unknown

19e. Informant's Name/Relationship (Type, Print)

Thomas C. Hammett, Jr.

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

20827 Emerald Dr., Hagerstown, Md. 21742

20e. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Hagerstown Crematory

Date

5-14-96

20c. Location - City or Town, State

Hagerstown, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

MINNICH FUNERAL HOME

415 E. Wilson Boulevard, Hagerstown, Maryland 21740

23e. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

a. Cystic Fibrosis
Due to (or as a consequence of):

b. Hepatic Cirrhosis/Fibrosis
Due to (or as a consequence of):

c. Gastrointestinal Bleeding
Due to (or as a consequence of):

d. Acute Respiratory Distress Syndrome
Due to (or as a consequence of):

e. Renal Failure

Approximate Interval Between Onset and Death

10 years

2 months

1 week

1 week

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24e. Was an autopsy performed?

1 ☒ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

N2167

29d. Date signed (Month, Day, Year)

May 12, 1996

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Chris Freer Johns Hopkins Hospital Baltimore Maryland

31. Date filed (Month, Day, Year)

MAY 15 1996

32. Registrar's Signature

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

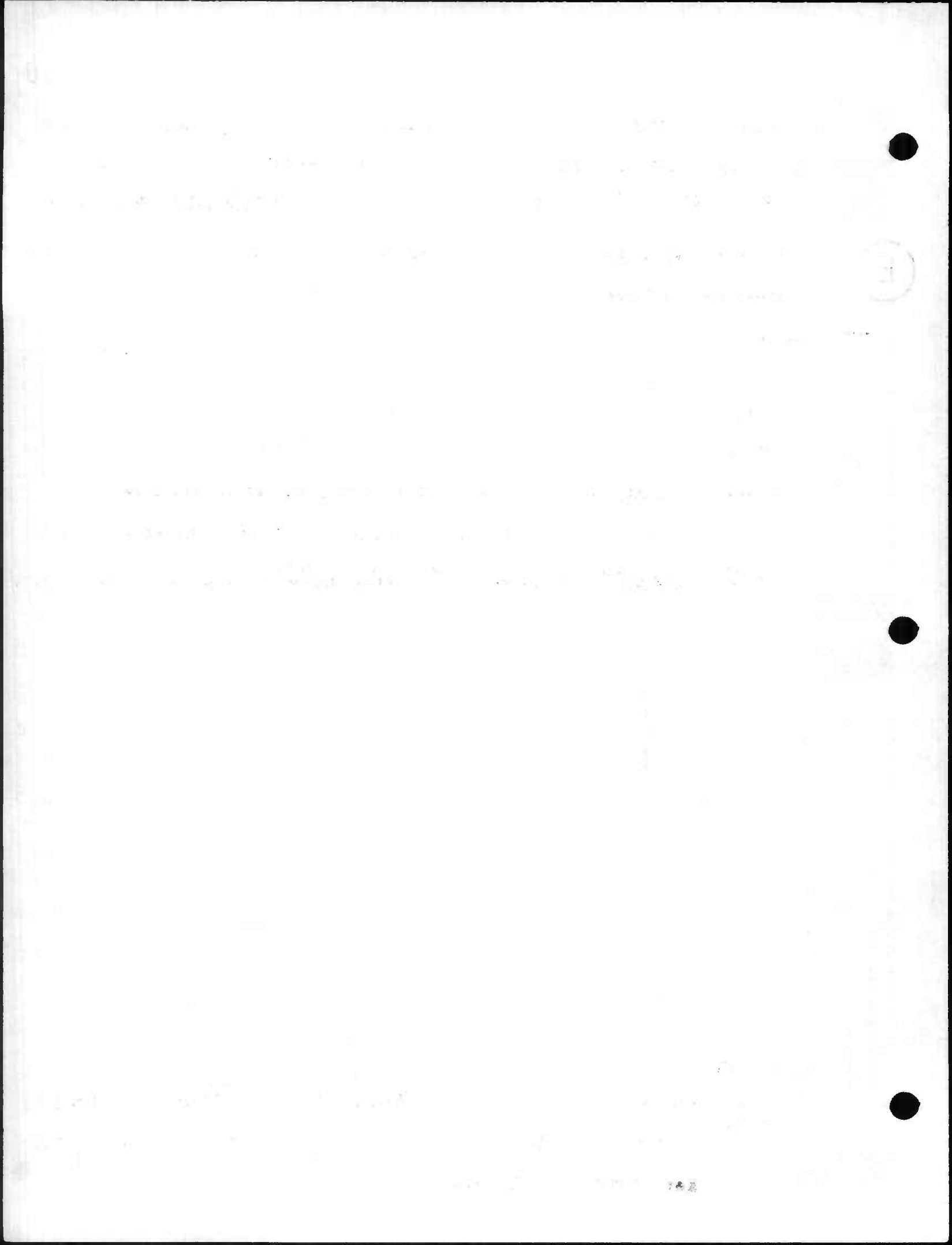
Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Amend #8 Wash. Co. L.B. May 15, 1996

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 15541

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) John Russell Mann <i>JOHN RUSSELL MANN</i>				2. Date of Death Month 05 Day 12 Year 96		3. Time of Death 21:03		
	4a. Facility Name (If not Institution, give street and number) Washington County Hospital				4b. City, Town, or Location of Death Hagerstown		4c. County of Death Washington		
Funeral Director	5. Social Security Number 173-03-3634		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 83 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) 6/16/1912	9. Birthplace (State or Foreign Country) Mercersburg, PA	
	Usual Residence of Decedent June								
To Be Completed by Funeral Director	10a. State PA		10b. County Franklin		10c. City, Town or Location Waynesboro			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
	10e. Street and Number 101 N. Broad Street				10f. Zip Code 17268		10g. Citizen of What Country? U.S.A.		
	11. Marital Status <input type="checkbox"/> Navar Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever In U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: white		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 11th College (1-4or 5+) 		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Boring Mill Operator			16b. Kind of Business/Industry Tool Co.			
	17. Father's Name (First, Middle, Last) Charles H. Mann				18. Mother's Name (First, Middle, Maiden Surname) Lydia Shives				
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Bette Mann wife				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 101 N. Broad Street, Waynesboro, PA 17268				
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Green Hill Cemetery		Date 5/16/96	20c. Location - City or Town, State Waynesboro, PA 17268			
	22. Name and Address of Facility Grove Funeral Home, Inc. 50 S. Broad St., Waynesboro, PA 17268							Approximate Interval Between Onset and Death 2 wks.	
	at caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, on each line. gastrointestinal bleeding Due to (or as a consequence of): angiodyplasia Due to (or as a consequence of): Chronic Obstructive Pulmonary disease yrs Due to (or as a consequence of): Coronary artery disease							Unknown	
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ① Disseminated intravascular coagulation ② Aneurysm								
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)				
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier		29c. License number		29d. Date signed (Month, Day, Year) May 12th 96.		
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SHAHAB Z SIDDIQUI MD. 1414-C WINTERBURG PK HAGERSTOWN MD 21742								
State Registrar	31. Date filed (Month, Day, Year) MAY 15 1996		32. Registrar's Signature <i>John Davidson</i>						

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 15542

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Evelyn Mae Molcan

2. Date of Death

May 13, 1996

3. Time of Death

7:30 AM

Funeral
Director

4a. Facility Name (If not institution, give street and number)

Maryland General Hospital

4b. City, Town, or Location of Death

Baltimore City

4c. County of Death

City

5. Social Security Number

113-24-7566

6. Sex

1 ☐ M ☒ F

7. Age (In yrs. last birthday)

88 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

May 4, 1908

9. Birthplace (State or Foreign Country)

Pennsylvania

Usual Residence of Decedent

10a. State

Md.

10b. County

Howard

10c. City, Town or Location

Mt. Airy

10d. Inside City Limits

1 ☐ Yes ☒ No

10e. Street and Number

13103 Penn Shop Rd.

10f. Zip Code

21771

10g. Citizen of What Country?

USA.

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

12

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Housewife

16b. Kind of Business/Industry

Home Making

17. Father's Name (First, Middle, Last)

John Robert Marnin

18. Mother's Name (First, Middle, Maiden Surname)

Sade Webster

19a. Informant's Name/Relationship (Type, Print)

John F. Molcan

- Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

13103 Penn Shop Rd., Mt. Airy, Md. 21771

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Carroll Cremation

Date

5/14/96

20c. Location - City or Town, State

Hampstead, Md.

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Fletcher Funeral Home

254 E. Main St., Westminster, Md. 21157

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

Fungemia (Systemic Fungal Infection)

Due to (or as a consequence of):
Acute Renal FailureDue to (or as a consequence of):
Congestive Heart Failure

Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

Inpatient

2 ☐ ER/Outpatient3 ☐ DOA

Other:

26. Place of Death (Check only one)

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

89258

29d. Date signed (Month, Day, Year)

May 13, 1996

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Suresh Verghese, M.D. c/o Maryland General Hospital

31. Date filed (Month, Day, Year)

MAY 14 1996

32. Registrar's Signature

John Michael Randall

State
Registrar

Baltimore, Maryland 21215-0020

permitted. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

96 15543

Amended, Item 6, ETN 5/10/96 Cecil Co.

FOR
1 - STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Charles Hamilton Martin				2. DATE OF DEATH MONTH DAY YEAR May 8 1996		3. TIME OF DEATH 0648 A M	
4. SOCIAL SECURITY NUMBER 212-01-7523		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 87 88 YRS.		7. DATE OF BIRTH (Month, Day, Year) February 28, 1908 Maryland	
9a. FACILITY NAME (If not institution, give street and number) Medpointe Continuing Care Center				9b. CITY, TOWN OR LOCATION OF DEATH Elkton		9c. COUNTY OF DEATH Cecil	
10a. STATE Maryland		10b. COUNTY Cecil		10c. CITY, TOWN OR LOCATION Elkton		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 2344 Oldfield Point Road				10f. ZIP CODE 21921		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (14 or 5+) 8		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Supervisor		16b. KIND OF BUSINESS/INDUSTRY Transportation			
17. FATHER'S NAME (First, Middle, Last) Harry E. Martin				18. MOTHER'S NAME (First, Middle, Maiden Surname) Idella Russell			
19a. INFORMANT'S NAME (Type/Print) Mary A. Laramore				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2335 Oldfield Point Road, Elkton, Maryland 21921			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Elkton Cemetery		DATE 5-10-96		20c. LOCATION — City or Town, State Elkton, Maryland	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Donald S. Hicks</i>				22. NAME AND ADDRESS OF FACILITY Hicks Home for Funerals, P.A. 103 W. Stockton St., Elkton, Maryland 21921			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>Metastatic Lung Cancer</i> DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							Approximate Interval Between Onset and Death 3 years
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DCA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 6 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Monte Makous</i> M.D.				29c. LICENSE NUMBER D-44783		29d. DATE SIGNED (Month, Day, Year) 5-9-96	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Monte Makous, M.D. 111 West High Street, Elkton, Maryland 21921							
31. DATE FILED (Month, Day, Year) MAY 10 1996				32. REGISTRAR'S SIGNATURE <i>John A. Russell</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 15544

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Billy Mack Morton				2. Date of Death Month Day Year May 9, 1996		3. Time of Death 4:30 A.		
	4a. Facility Name (If not institution, give street and number) Careplex Nursing Home Center				4b. City, Town, or Location of Death Silver Spring		4c. County of Death Montgomery		
Funeral Director	5. Social Security Number 244-14-2904	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 73 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Oct 1, 1922		9. Birthplace (State or Foreign Country) North Carolina	
	Usual Residence of Decedent								
To Be Completed by Funeral Director	10a. State Maryland	10b. County Prince George	10c. City, Town or Location Suitland			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
	10e. Street and Number 6123 Auth Road			10f. Zip Code 20746		10g. Citizen of What Country? United States			
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: 1965-1969		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+)			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Golf Cart Salesman			16b. Kind of Business/Industry Tri State Golf Cart		
	17. Father's Name (First, Middle, Last) Thomas Morton				18. Mother's Name (First, Middle, Maiden Surname) Nanny (UNKNOWN)				
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Allison K. Landers				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1604 Danton Lane, Mitchellville, Maryland 20721				
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Maryland Veterans Cemetery		20c. Location - City or Town, State Cheltenham, Maryland		20d. Location - City or Town, State Cheltenham, Maryland		
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Lee Funeral Home, Inc 6633 Old Alexandria Ferry Rd, Clinton, Md 20735				
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. Acute pulmonary embolism Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								
	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how Injury occurred	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier 		29c. License number 006674		29d. Date signed (Month, Day, Year) 5/9/96			
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) MYRON L. LENKIN MD 23090 HOREFIELD RD WHEATON MD									
31. Date filed (Month, Day, Year) MAY 15 1996				32. Registrar's Signature 					

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

①

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 15545

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) MONICA MARY MCPARTLAND				2. Date of Death Month APRIL Day 29 Year 1996		3. Time of Death 11:35 AM	
	4a. Facility Name (If not institution, give street and number) Sacred Heart Hospital				4b. City, Town, or Location of Death Cumberland		4c. County of Death Allegany	
Funeral Director	5. Social Security Number 212-38-5715	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 89 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) May 16 1906		9. Birthplace (State or Foreign Country) Maryland
	Usual Residence of Decedent							
To Be Completed by Funeral Director	10a. State Maryland	10b. County Allegany	10c. City, Town or Location Barton			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
	10e. Street and Number Legislative Road			10f. Zip Code 21521		10g. Citizen of What Country? United States		
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 4		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) School Teacher		16b. Kind of Business/Industry Education			
	17. Father's Name (First, Middle, Last) Harmon Arnold			18. Mother's Name (First, Middle, Maiden Surname) Dahlia Monahan				
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Sally Borgman			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Florida Way, Lonaconing, Md. 21539				
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Saint Gabriel's Cem.		20c. Location - City or Town, State 5-2-96 Barton, Md.			
	21. Signature of Funeral Service Licensee 		22. Name and Address of Facility Boal Funeral Home 111 Church St. Westernport, Md. 21562					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Urosepsis Dua to (or as a consequence of): b. Dua to (or as a consequence of): c. Dua to (or as a consequence of): d. Dua to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							Approximate Interval Between Onset and Death 12 hrs
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. aortic valve replacement 2 yrs previously							23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how Injury occurred
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier 		29c. License number 009231		29d. Date signed (Month, Day, Year) MAY 1 1996		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DONALD MANAGER 70 Main St Lonaconing Md 21539								
31. Date filed (Month, Day, Year) MAY 07 1996		32. Registrar's Signature 						

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

State
Registrar

96 15546

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Samuel Morgan				2. DATE OF DEATH MONTH DAY YEAR May 7, 1996				3. TIME OF DEATH 11:37 AM			
4. SOCIAL SECURITY NUMBER 216 05 5318				5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 85 YRS.		7. DATE OF BIRTH (Month, Day, Year) MAY 29, 1910		8. BIRTHPLACE (State or Foreign Country) MARYLAND	
9a. FACILITY NAME (If not institution, give street and number) FROSTBURG VILLAGE NURSING HOME						9b. CITY, TOWN OR LOCATION OF DEATH FROSTBURG			9c. COUNTY OF DEATH ALLEGANY		
RESIDENCE OF DECEDENT											
10a. STATE MARYLAND			10b. COUNTY ALLEGANY			10c. CITY, TOWN OR LOCATION FROSTBURG			10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		
10e. STREET AND NUMBER 12230 CARLOS ROAD, SW						10f. ZIP CODE 21532			10g. CITIZEN OF WHAT COUNTRY? U.S.		
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced			12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES			13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: WHITE		
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 6 College (1-4 or 5+) 6				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) JANITOR				16b. KIND OF BUSINESS/INDUSTRY TEXTILE			
17. FATHER'S NAME (First, Middle, Last) DAVID WILLIAM MORGAN						18. MOTHER'S NAME (First, Middle, Maiden Surname) MARY CATHERINE KOONTZ					
19a. INFORMANT'S NAME (Type/Print) MARY ELLEN MORGAN / WIFE						19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12230 CARLOS ROAD, SW, FROSTBURG, MD 21532					
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) GREEN CEMETERY 5/9/96				20c. LOCATION — City or Town, State LONACONING, MD 21539			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Maribou M. Sowers</i>						22. NAME AND ADDRESS OF FACILITY SOWERS FUNERAL HOME, P.A. 60 W. MAIN ST., FROSTBURG, MD 21532					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST a. CHRONIC OBSTRUCTIVE LUNG DISEASE DUE TO (OR AS A CONSEQUENCE OF): b. BLACK LUNG DISEASE DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF):										Approximate Interval Between Onset and Death 20 yrs. 20 yrs.	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. CORONARY ARTERY DISEASE MYOCARDIAL INFARCTION PEPTIC ULCER DISEASE											
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>											
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)						28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
29b. SIGNATURE AND TITLE OF CERTIFIER <i>H. Sidhu</i>						29c. LICENSE NUMBER D26907			29d. DATE SIGNED (Month, Day, Year) MAY 8, 1996		
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) HARJIT S. SIDHU, M.D. 925 BISHOP WALSH ROAD, CUMBERLAND, MD 21502											
31. DATE FILED (Month, Day, Year) MAY 10 1996						32. REGISTRAR'S SIGNATURE <i>Jane D. H. H. H.</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION


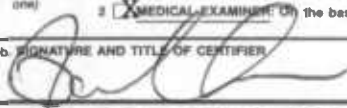

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

96 15547

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) EARL ROBERT MULLENAX		2. DATE OF DEATH MONTH May DAY 14 , YEAR 1996		3. TIME OF DEATH 12:30 PM	
4. SOCIAL SECURITY NUMBER 217-32-6202		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 63 YRS.	
7. DATE OF BIRTH (Month, Day, Year) Apr 15, 1933		8. BIRTHPLACE (State or Foreign Country) MD			
9a. FACILITY NAME (If not institution, give street and number) MEMORIAL HOSPITAL		9b. CITY, TOWN OR LOCATION OF DEATH CUMBERLAND		9c. COUNTY OF DEATH ALLEGANY	
10a. STATE MD		10b. COUNTY Allegany		10c. CITY, TOWN OR LOCATION Oldtown	
10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER Frog Hollow Road SE		10f. ZIP CODE 21555	
10g. CITIZEN OF WHAT COUNTRY? USA		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES Vietnam	
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: white		15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 	
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Retired		16b. KIND OF BUSINESS/INDUSTRY U.S. Marine Corps		17. FATHER'S NAME (First, Middle, Last) Lester Mullenax	
18. MOTHER'S NAME (First, Middle, Maiden Surname) Martha O. (Carder)		19a. INFORMANT'S NAME (Type/Print) Gladys L. Mullenax		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) Frog Hollow Road SE; Oldtown, MD 21555	
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Sunset Memorial Park		20c. LOCATION — City or Town, State 05/17 Cumberland, MD	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 		22. NAME AND ADDRESS OF FACILITY Scarpelli Funeral Home Cumberland, MD 21502		23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Arteriosclerotic Cardiovascular Heart Disease Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST a. Hyperlipidemia b. c. d. 	
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input checked="" type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		27. MANNER OF DEATH X <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 6 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year) 	
28b. TIME OF INJURY M 		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED 	
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 		29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.	
29b. SIGNATURE AND TITLE OF CERTIFIER 		29c. LICENSE NUMBER D09157		29d. DATE SIGNED (Month, Day, Year) May 14, 1996	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Dr. Paul Snow; 124 W. Third Street; Cumberland, MD 21502		31. DATE FILED (Month, Day, Year) MAY 15 1996		32. REGISTRAR'S SIGNATURE 	

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3, 4, and 6 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

File

7

B.K.S. *Amend # 46, 5/8/96*
N.B.S., Allegany County

State of Maryland / Department of Health and Mental Hygiene

96 15548

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) DEBRA A. NAU				2. Date of Death Month Day Year MAY 05, 1996		3. Time of Death 1523 PM		
	4a. Facility Name (If not institution, give street and number) 635-B OLD FROSTBURG ROAD				4b. City, Town, or Location of Death FROSTBURG		4c. County of Death GARRETT		
Funeral Director	5. Social Security Number 220-76-4178	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 40 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Aug 23, 1955	9. Birthplace (State or Foreign Country) MD		
	Usual Residence of Decedent								
To Be Completed by Funeral Director	10a. State MD	10b. County Garrett	10c. City, Town or Location Finzel			10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
	10e. Street and Number 635-B Old Frostburg Road			10f. Zip Code 21532		10g. Citizen of What Country? USA			
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: white		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+)			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker			16b. Kind of Business/Industry Own Home		
	17. Father's Name (First, Middle, Last) Frank Leroy Casteel				18. Mother's Name (First, Middle, Maiden Surname) Agnes (Sturtz)				
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Frank Casteel--father			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2H Fort Cumberland Homes; Cumberland, MD 21502					
	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Cumberland Crematory		Date 05/08		20c. Location - City or Town, State Cumberland, MD		
	21. Signature of Funeral Service Licensee <i>James F. Scarpelli</i>			22. Name and Address of Facility Scarpelli Funeral Home Cumberland, MD 21502					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Gun shot and blunt force injuries of head Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		
24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No						24b. Were autopsy findings available prior to completion of cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No			
25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. Manner of Death 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input checked="" type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year) 5-5-96		28b. Time of Injury 1435 M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		28d. Describe how injury occurred Subject shot and beaten	
29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) as stated.		29b. Signature and title of certifier <i>[Signature]</i>		29c. License number O.C.M.E		29d. Date signed (Month, Day, Year) MAY 06, 1996		28f. Location (Street and Number or Rural Route Number, City or Town, State) 635 B Old Frostburg Rd	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) David R Fowler 111 Penn Street, Baltimore, Maryland 21201									
31. Date filed (Month, Day, Year) MAY 08 1996				32. Registrar's Signature <i>[Signature]</i>					

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 15549

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

DANIEL THOMAS NIGHTINGALE

2. Date of Death
Month Day Year

APRIL 30 1996

3. Time of Death

1815

4a. Facility Name (If not institution, give street and number)

Sacred Heart Hospital

4b. City, Town, or Location of Death

Cumberland

4c. County of Death

Allegheny

Funeral
Director

5. Social Security Number

214-07-3223

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

90 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth
(Month, Day, Year)

March 2 1906

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Allegheny

10c. City, Town or Location

Lonaconing

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

31 Jackson St.

10f. Zip Code

21539

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4or 5+)

Unknown

16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)

Painter Celanese Corp.

16b. Kind of Business/Industry

Manufacturing

17. Father's Name (First, Middle, Last)

Daniel Nightingale

18. Mother's Name (First, Middle, Maiden Summa)

Margaret Reese

19a. Informant's Name/Relationship (Type, Print)

Jack Nightingale

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

32 Allegheny St. Lonaconing, Md. 21539

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Oak Hill Cemetery 5-3-96

Data

20c. Location - City or Town, State

Lonaconing, Md.

21. Signature of Funeral Service Licensee

Wayne Beal

22. Name and Address of Facility

Boal Funeral Home
41 Main St. Lonaconing, Md. 21539

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Congestive Heart Failure

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

2 years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Aortic Stenosis

Due to (or as a consequence of):

10 years

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Chronic obstructive pulmonary disease

Atherosclerotic coronary artery disease

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined28a. Date of Injury
(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier
(Check only one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Thomas J. Devlin MD

29c. License number

D21488

29d. Date signed (Month, Day, Year)

MAY 1 1996

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Thomas J. Devlin MD, 20 Douglas Ave., Lonaconing, Md 21539

31. Date filed (Month, Day, Year)

MAY 07 1996

32. Registrar's Signature

John Davidson-Randall

State
Registrar

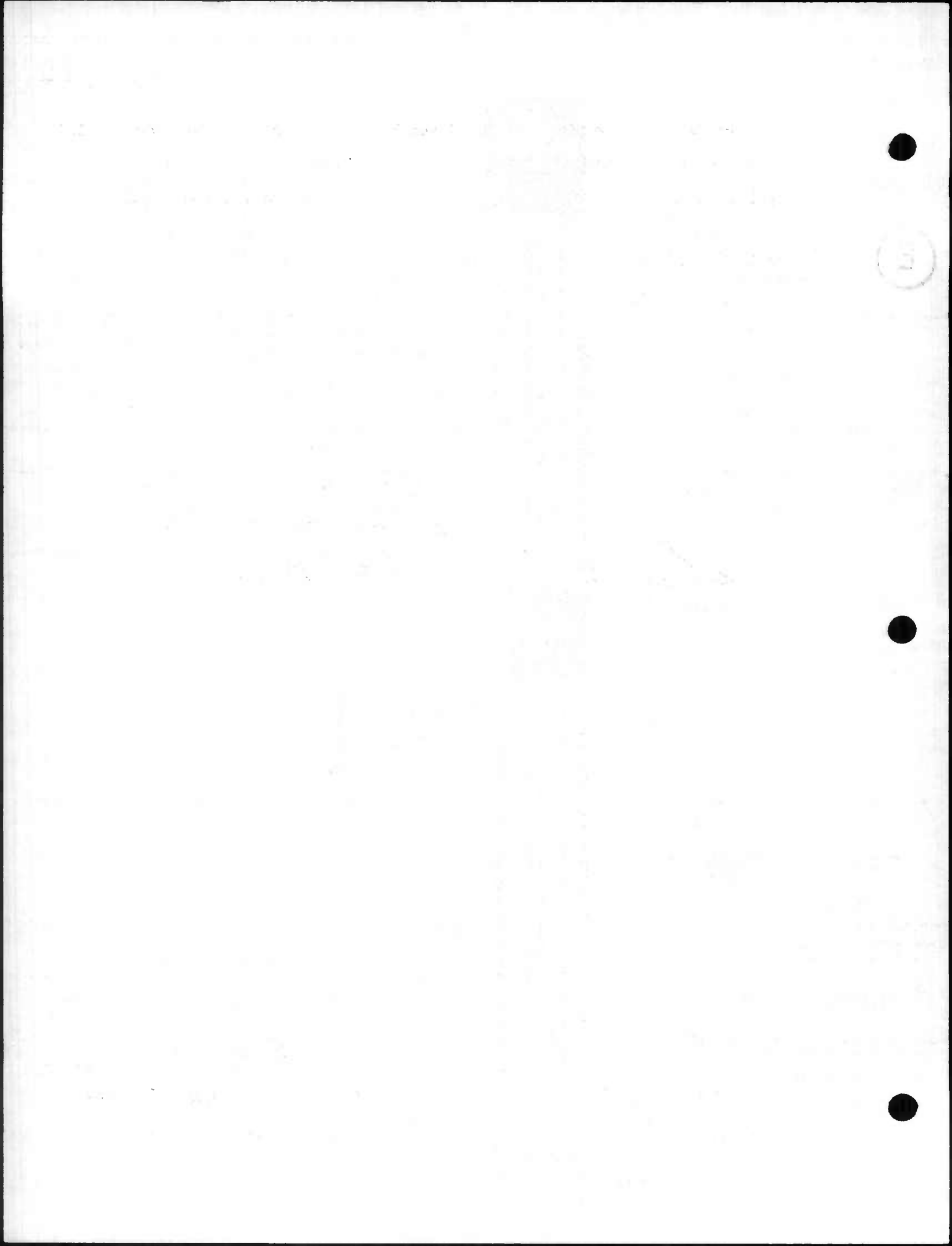
Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 15550

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Joseph Norbert Pohlhaus				2. Date of Death Month May Day 12 , Year 1996		3. Time of Death 11:30A.M.	
	4a. Facility Name (If not institution, give street and number) 1439 Old Taneytown Rd.				4b. City, Town, or Location of Death Westminster		4c. County of Death Carroll	
Funeral Director	5. Social Security Number 219-01-2684		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 78 Yrs.		8. Date of Birth (Month, Day, Year) 3-20-1918	
	9. Birthplace (State or Foreign Country) Maryland		10e. State Maryland		10b. County Carroll		10c. City, Town or Location Westminster	
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		10e. Street and Number 1439 Old Taneytown Rd.		10f. Zip Code 21158		10g. Citizen of What Country? U.S.A.	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) 4		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Farmer		16b. Kind of Business/Industry Agriculture			
	17. Father's Name (First, Middle, Last) John Michael Pohlhaus				18. Mother's Name (First, Middle, Maiden Surname) Agnes Schuette			
	19a. Informant's Name/Relationship (Type, Print) Joan P. Lewis - Daughter				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1237 Old Taneytown Rd. Westminster, Md. 21158			
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Evergreen Mem. Gardens		Date 5/15		20c. Location - City or Town, State Finksburg, Md.	
	21. Signature of Funeral Service Licensee				22. Name and Address of Facility FLETCHER FUNERAL HOME 254 East Main Street, Westminster, Md. 21157			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. METASTATIC NEUROENDOCRINE CA a. Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):							
	23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown							
	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No							
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No								
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No							
	26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28d. Describe how injury occurred			
	28f. Location (Street and Number or Rural Route Number, City or Town, State)							
	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
	29b. Signature and title of certifier [Signature]				29c. License number D35398		29d. Date signed (Month, Day, Year) 5/14/96	
	30. Name and address of person who completed cause of death (item 23a) (Type, Print)							
	31. Date filed (Month, Day, Year) MAY 14 1996							
	32. Registrar's Signature [Signature]							

Baltimore, Maryland 21215-0020

Department of Health and Mental Hygiene

Important: If item 27 is marked other than "natural", causes 23a or 23b-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

Amended Item #2, 5/14/96

State of Maryland / Department of Health and Mental Hygiene

96 15551

Per F.D., Carroll County, WJL Amended item # 8
5/15/96 C.C. P.L.C. Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Dora Elizabeth Puckett			2. Date of Death Month 05 Day 13 Year 1996		3. Time of Death 13:02	
	4a. Facility Name (If not Institution, give street and number) Carroll County General Hospital			4b. City, Town, or Location of Death Westminster		4c. County of Death Carroll	
Funeral Director	5. Social Security Number 218-36-8708		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 77 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Jan. 16, 1919
	9. Birthplace (State or Foreign Country) Virginia						
Usual Residence of Decedent							
10a. State MD		10b. County Carroll		10c. City, Town or Location Union Bridge		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10e. Street and Number 419 Clear Ridge Road				10f. Zip Code 21791		10g. Citizen of What Country? United States	
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) worker		16b. Kind of Business/Industry furniture manufacturer	
17. Father's Name (First, Middle, Last) Charlie Johnson				18. Mother's Name (First, Middle, Maiden Surname) Gertrude Woodie			
19a. Informant's Name/Relationship (Type, Print) James C. Puckett, son				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2840 Uniontown Rd., Westminster, MD 21158			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Uniontown Lutheran Cemetery		Date 5/17/96		20c. Location - City or Town, State Uniontown, MD	
21. Signature of Funeral Service Licensee Katherine Pritts - Switzer				22. Name and Address of Facility Pritts Funeral Home & Chapel 412 Washington Rd., Westminster, MD 21157			
23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. Cerebrovascular Accident Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last 3 days							
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Conjunctive Heart Failure							
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown							
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28d. Describe how injury occurred			
28f. Location (Street and Number or Rural Route Number, City or Town, State)							
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. Signature and title of certifier Katherine Pritts - Switzer				29c. License number D18200		29d. Date signed (Month, Day, Year) 5/13/96	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TO CHITACHEDU MARGANNA 700A POOLE RD WESTMINSTER MD 21157							
31. Date filed (Month, Day, Year) MAY 14 1996				32. Registrar's Signature John Andrew Randall			

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

State
Registrar

DHMH 16 Rev 6/95

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State of Maryland / Department of Health and Mental Hygiene

96 15552

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Timothy Clyde Proctor				2. Date of Death Month Day Year May 11, 1996		3. Time of Death 12:50PM	
	4a. Facility Name (If not Institution, give street and number) Southern Maryland Hospital				4b. City, Town, or Location of Death Clinton		4c. County of Death Prince George's	
Funeral Director	5. Social Security Number 220-74-7786		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 37 Yrs.		8. Date of Birth (Month, Day, Year) July 7, 1958	
	9. Birthplace (State or Foreign Country) Maryland		10a. State Maryland		10b. County Prince George's		10c. City, Town or Location Suitland	
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		10e. Street and Number 6711 Larches Court		10f. Zip Code 20746		10g. Citizen of What Country? U.S.A.	
	11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black	
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (1-4or 5+) N/A		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Custodian		16b. Kind of Business/Industry Base Andrews Air Force		17. Father's Name (First, Middle, Last) James G. Proctor Sr.	
	18. Mother's Name (First, Middle, Maiden Summa) Mildred E. Harley		19a. Informant's Name/Relationship (Type, Print) Cheryl A. Garner		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13208 Water Fowl Way Upper Marlboro, Maryland 20772		20. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)	
To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee [Signature]		22. Name and Address of Facility Lee Funeral Home, Inc. 6633 Old Alexandria Ferry Rd Clinton, Md 20735		23a. Pert. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Hypovolemia, Delapatal Due to (or as a consequence of): b. HIV infection Due to (or as a consequence of): c. Disseminated H-2 infection Due to (or as a consequence of): d. Acute Gastric Enteritis		Approximate Interval Between Onset and Death 1/2 hr	
	23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown		24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. Guaranteed Syndrome Bendments. Enterococci Hypokalemia	
Medical Certification: To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify)		27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)	
	28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how Injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier [Signature]		29c. License number		29d. Date signed (Month, Day, Year) 5-11-96	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ABULHASAN U ANSARI MD. 8926 Woodland Rd #101 Clinton Md. 20735		31. Date filed (Month, Day, Year) MAY 15 1996		32. Registrar's Signature Julia Davidson-Randall		State Registrar	

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 15553

Physician
/Medical
Examiner

Funeral
Director

1. Decedent's Name (First, Middle, Last) VIRGINIA GERARDINE PRICHARD				2. Date of Death Month Day Year May 5, 1996		3. Time of Death 4:10 A.M.	
4a. Facility Name (If not institution, give street and number) Memorial Hospital				4b. City, Town, or Location of Death Cumberland		4c. County of Death Allegany	
5. Social Security Number 212-38-7684		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 91 Yrs.		8. Date of Birth (Month, Day, Year) Sept. 26, 1904	
9. Birthplace (State or Foreign Country) West Virginia		10a. State Maryland		10b. County Allegany		10c. City, Town or Location La Vale	
10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number 120 Park Avenue		10f. Zip Code 21502		10g. Citizen of What Country? USA	
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: white	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 5+ Collage (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) School Teacher		16b. Kind of Business/Industry Education		17. Father's Name (First, Middle, Last) Edward T. Pritchard	
18. Mother's Name (First, Middle, Maiden Surname) Virginia Duty		19a. Informant's Name/Relationship (Type, Print) Orpha-Bonita Pritchard		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 120 Park Ave. LaVale, Md. 21502		20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)	
20b. Place of Disposition (Name of cemetery, crematory or other place) Hillcrest Burial Park		20c. Location - City or Town, State 5-8-96 Cumberland, Md.		21. Signature of Funeral Service Licensee Ernest A. Riley, Jr.		22. Name and Address of Facility Leasure-Stein, Inc. 230 Baltimore Avenue Cumberland, Maryland 21502	
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Coronary Artery Disease Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							Approximate Interval Between Onset and Death 5 years
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Hypercarbic Respiratory Failure							23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.	
29b. Signature and title of certifier [Signature]		29c. License number D 33280		29d. Date signed (Month, Day, Year) May 6, 1996		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sunil Gupta, M.D., 625 Kent Ave., Cumberland, Md. 21502	
31. Date filed (Month, Day, Year) MAY 09 1996		32. Registrar's Signature [Signature]					

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 15554

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Lloyd E. Perkins Sr.				2. Date of Death Month May Day 9 Year 1996		3. Time of Death 10:00 am	
	4a. Facility Name (If not institution, give street and number) Memorial Hospital & Medical Center				4b. City, Town, or Location of Death Cumberland		4c. County of Death Allegany	
Funeral Director	5. Social Security Number 217-10-5037	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 78 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) September 11, 1917		9. Birthplace (State or Foreign Country) Maryland
	Usual Residence of Decedent							
10a. State Maryland		10b. County Allegany		10c. City, Town or Location Frostburg			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10e. Street and Number 19309 Old Dans Rock Road S.W.				10f. Zip Code 21532		10g. Citizen of What Country? U.S.A.		
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: 1945		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4or 5+) 0				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Spinning Dept.		16b. Kind of Business/Industry Textiles		
17. Father's Name (First, Middle, Last) Joseph Perkins				18. Mother's Name (First, Middle, Maiden Surname) Mary Humbertson				
19a. Informant's Name/Relationship (Type, Print) Joy Perkins / Wife				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19309 Old Dans Rock Road S.W. Frostburg, Md. 21532				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Eckhart Cemetery		Date May 13, 1996		20c. Location - City or Town, State Eckhart, Maryland	
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Durst Funeral Home 57 Frost Avenue Frostburg, Maryland 21532				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Ruptured Abdominal Aortic Aneurysm Due to (or as a consequence of): Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):								Approximate Interval Between Onset and Death 12 Days
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Renal Failure						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier 				29c. License number D 17456		29d. Date signed (Month, Day, Year) 5/13/96		
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Dr. Phillip Schroeder-4th Floor-Memorial Hospital-Cumberland, MD 21502								
31. Date filed (Month, Day, Year) MAY 14 1996				32. Registrar's Signature 				

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

5
7/28State
Registrar

1941. 1942. 1943. 1944. 1945. 1946. 1947. 1948. 1949. 1950. 1951. 1952. 1953. 1954. 1955. 1956. 1957. 1958. 1959. 1960. 1961. 1962. 1963. 1964. 1965. 1966. 1967. 1968. 1969. 1970. 1971. 1972. 1973. 1974. 1975. 1976. 1977. 1978. 1979. 1980. 1981. 1982. 1983. 1984. 1985. 1986. 1987. 1988. 1989. 1990. 1991. 1992. 1993. 1994. 1995. 1996. 1997. 1998. 1999. 2000. 2001. 2002. 2003. 2004. 2005. 2006. 2007. 2008. 2009. 2010. 2011. 2012. 2013. 2014. 2015. 2016. 2017. 2018. 2019. 2020. 2021. 2022. 2023. 2024. 2025. 2026. 2027. 2028. 2029. 2030. 2031. 2032. 2033. 2034. 2035. 2036. 2037. 2038. 2039. 2040. 2041. 2042. 2043. 2044. 2045. 2046. 2047. 2048. 2049. 2050. 2051. 2052. 2053. 2054. 2055. 2056. 2057. 2058. 2059. 2060. 2061. 2062. 2063. 2064. 2065. 2066. 2067. 2068. 2069. 2070. 2071. 2072. 2073. 2074. 2075. 2076. 2077. 2078. 2079. 2080. 2081. 2082. 2083. 2084. 2085. 2086. 2087. 2088. 2089. 2090. 2091. 2092. 2093. 2094. 2095. 2096. 2097. 2098. 2099. 2100. 2101. 2102. 2103. 2104. 2105. 2106. 2107. 2108. 2109. 2110. 2111. 2112. 2113. 2114. 2115. 2116. 2117. 2118. 2119. 2120. 2121. 2122. 2123. 2124. 2125. 2126. 2127. 2128. 2129. 2130. 2131. 2132. 2133. 2134. 2135. 2136. 2137. 2138. 2139. 2140. 2141. 2142. 2143. 2144. 2145. 2146. 2147. 2148. 2149. 2150. 2151. 2152. 2153. 2154. 2155. 2156. 2157. 2158. 2159. 2160. 2161. 2162. 2163. 2164. 2165. 2166. 2167. 2168. 2169. 2170. 2171. 2172. 2173. 2174. 2175. 2176. 2177. 2178. 2179. 2180. 2181. 2182. 2183. 2184. 2185. 2186. 2187. 2188. 2189. 2190. 2191. 2192. 2193. 2194. 2195. 2196. 2197. 2198. 2199. 2200. 2201. 2202. 2203. 2204. 2205. 2206. 2207. 2208. 2209. 2210. 2211. 2212. 2213. 2214. 2215. 2216. 2217. 2218. 2219. 2220. 2221. 2222. 2223. 2224. 2225. 2226. 2227. 2228. 2229. 2230. 2231. 2232. 2233. 2234. 2235. 2236. 2237. 2238. 2239. 2240. 2241. 2242. 2243. 2244. 2245. 2246. 2247. 2248. 2249. 2250. 2251. 2252. 2253. 2254. 2255. 2256. 2257. 2258. 2259. 2260. 2261. 2262. 2263. 2264. 2265. 2266. 2267. 2268. 2269. 2270. 2271. 2272. 2273. 2274. 2275. 2276. 2277. 2278. 2279. 2280. 2281. 2282. 2283. 2284. 2285. 2286. 2287. 2288. 2289. 2290. 2291. 2292. 2293. 2294. 2295. 2296. 2297. 2298. 2299. 2300. 2301. 2302. 2303. 2304. 2305. 2306. 2307. 2308. 2309. 2310. 2311. 2312. 2313. 2314. 2315. 2316. 2317. 2318. 2319. 2320. 2321. 2322. 2323. 2324. 2325. 2326. 2327. 2328. 2329. 2330. 2331. 2332. 2333. 2334. 2335. 2336. 2337. 2338. 2339. 2340. 2341. 2342. 2343. 2344. 2345. 2346. 2347. 2348. 2349. 2350. 2351. 2352. 2353. 2354. 2355. 2356. 2357. 2358. 2359. 2360. 2361. 2362. 2363. 2364. 2365. 2366. 2367. 2368. 2369. 2370. 2371. 2372. 2373. 2374. 2375. 2376. 2377. 2378. 2379. 2380. 2381. 2382. 2383. 2384. 2385. 2386. 2387. 2388. 2389. 2390. 2391. 2392. 2393. 2394. 2395. 2396. 2397. 2398. 2399. 2400. 2401. 2402. 2403. 2404. 2405. 2406. 2407. 2408. 2409. 2410. 2411. 2412. 2413. 2414. 2415. 2416. 2417. 2418. 2419. 2420. 2421. 2422. 2423. 2424. 2425. 2426. 2427. 2428. 2429. 2430. 2431. 2432. 2433. 2434. 2435. 2436. 2437. 2438. 2439. 2440. 2441. 2442. 2443. 2444. 2445. 2446. 2447. 2448. 2449. 2450. 2451. 2452. 2453. 2454. 2455. 2456. 2457. 2458. 2459. 2460. 2461. 2462. 2463. 2464. 2465. 2466. 2467. 2468. 2469. 2470. 2471. 2472. 2473. 2474. 2475. 2476. 2477. 2478. 2479. 2480. 2481. 2482. 2483. 2484. 2485. 2486. 2487. 2488. 2489. 2490. 2491. 2492. 2493. 2494. 2495. 2496. 2497. 2498. 2499. 2500. 2501. 2502. 2503. 2504. 2505. 2506. 2507. 2508. 2509. 2510. 2511. 2512. 2513. 2514. 2515. 2516. 2517. 2518. 2519. 2520. 2521. 2522. 2523. 2524. 2525. 2526. 2527. 2528. 2529. 2530. 2531. 2532. 2533. 2534. 2535. 2536. 2537. 2538. 2539. 2540. 2541. 2542. 2543. 2544. 2545. 2546. 2547. 2548. 2549. 2550. 2551. 2552. 2553. 2554. 2555. 2556. 2557. 2558. 2559. 2560. 2561. 2562. 2563. 2564. 2565. 2566. 2567. 2568. 2569. 2570. 2571. 2572. 2573. 2574. 2575. 2576. 2577. 2578. 2579. 2580. 2581. 2582. 2583. 2584. 2585. 2586. 2587. 2588. 2589. 2590. 2591. 2592. 2593. 2594. 2595. 2596. 2597. 2598. 2599. 2600. 2601. 2602. 2603. 2604. 2605. 2606. 2607. 2608. 2609. 2610. 2611. 2612. 2613. 2614. 2615. 2616. 2617. 2618. 2619. 2620. 2621. 2622. 26

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X

X

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 15555

Certificate of Death

Reg. No.

| | | | | | |
|---|--|--|---|---|---|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Chester Daniel Ralston, Jr. | | 2. Date of Death
Month May Day 5 Year 1996 | | 3. Time of Death
0840 |
| | 4a. Facility Name (If not institution, give street and number)
PENINSULA REGIONAL MEDICAL CENTER | | 4b. City, Town, or Location of Death
SALISBURY | | 4c. County of Death
WICOMICO |
| Funeral
Director | 5. Social Security Number
020-34-6367 | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)
49 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. |
| | 8. Date of Birth (Month, Day, Year)
12/2/1946 | | 9. Birthplace (State or Foreign Country)
Massachusetts | | |
| To Be Completed by Funeral Director | Usual Residence of Decedent
10e. State Maryland 10b. County Worcester | | 10c. City, Town or Location
Pocomoke City | | 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| | 10e. Street and Number
1727 New Bridge Road | | 10f. Zip Code
21851 | | 10g. Citizen of What Country?
USA |
| | 11. Marital Status
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |
| | 14. Race - American Indian, Black, White, etc.
Specify: White | | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (1-4 or 5+) 2 | | |
| | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Hotel Inspector | | 16b. Kind of Business/Industry | | |
| | 17. Father's Name (First, Middle, Last)
Chester Daniel Ralston, Sr. | | 18. Mother's Name (First, Middle, Maiden Surname)
Eva Ford | | |
| | 19a. Informant's Name/Relationship (Type, Print)
Denise Ralston - Wife | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1727 New Bridge Rd., Pocomoke City, Md. 21851 | | |
| | 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Eastlawn Cemetery | | 20c. Location - City or Town, State
5/9/1996 Williamstown, Mass. |
| | 21. Signature of Funeral Service Licensee
Scott S. Melson | | 22. Name and Address of Facility
Melson Funeral Home
PO BOX 64, Pocomoke City, Md. 21851 | | |
| | 23e. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | |
| Physician
/Medical
Examiner | Immediate Cause (Final disease or condition resulting in death) | | a. Septic Shock | | Approximate interval between Onset and Death
24 hours |
| | Due to (or as a consequence of): | | b. Aspiration Pneumonitis | | 24 hours |
| | Due to (or as a consequence of): | | c. Chemotherapy-Induced Neutropenia | | 4 days |
| | Due to (or as a consequence of): | | d. Diffuse Large Cell lymphoma | | 4 months |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | |
| | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | | | |
| | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| | 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | |
| | 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of injury (Month, Day Year) | | 28b. Time of Injury
M |
| | 28c. Injury at Work?
<input type="checkbox"/> Yes <input type="checkbox"/> No | | 28d. Describe how injury occurred | | |
| 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | |
| 29b. Signature and title of certifier
J. E. Martin M.D. | | 29c. License number
030690 | | 29d. Date signed (Month, Day, Year)
May 5, 1996 | |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)
James E. Martin, M.D., 145 E. Carroll St., Salisbury, MD. | | | | | |
| State Registrar | 31. Date filed (Month, Day, Year)
MAY 09 1996 | | 32. Registrar's Signature
John Anderson-Randall | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

96 15556

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | |
|---|--|--|--|---|--|--|---|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
Floyd Runyon | | | | 2. DATE OF DEATH
MONTH DAY YEAR
May 10, 1996 | | | | 3. TIME OF DEATH
2:05 A M | |
| 4. SOCIAL SECURITY NUMBER
235-52-5985 | | 5. SEX
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | 6. AGE (In yrs. last birthday)
61 YRS. | 7. DATE OF BIRTH (Month, Day, Year)
March 18, 1935 | | 8. BIRTHPLACE (State or Foreign Country)
W. Va. | | | |
| 9a. FACILITY NAME (If not institution, give street and number)
96 Murray Road | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
Elkton | | | 9c. COUNTY OF DEATH
Cecil | | |
| RESIDENCE OF DECEDENT | | | | | | | | | |
| 10a. STATE
Maryland | | 10b. COUNTY
Cecil | | 10c. CITY, TOWN OR LOCATION
Elkton | | | | 10d. INSIDE CITY LIMITS?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 10e. STREET AND NUMBER
96 Murray Road | | | | 10f. ZIP CODE
21921 | | 10g. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | |
| 11. MARITAL STATUS
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO
IF YES, GIVE WAR OR DATES
Korean | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | | 14. RACE — American Indian, Black, White, etc.
Specify: White | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (1-4 or 5+) College | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
Material Handler | | | 16b. KIND OF BUSINESS/INDUSTRY
Chrysler Corp. | | |
| 17. FATHER'S NAME (First, Middle, Last)
Delmas Runyon | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Anna Curry | | | | | |
| 19a. INFORMANT'S NAME (Type/Print)
Nancy L. Runyon | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
96 Murray Rd., Elkton, Md. 21921 | | | | | |
| 20a. METHOD OF DISPOSITION
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
Union Cemetery 5/14/96 | | 20c. LOCATION — City or Town, State
Union, Maryland | | | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
<i>Edward H. McKinnon</i> | | | | 22. NAME AND ADDRESS OF FACILITY
Gee Funeral Home 259 E. Main Street, Elkton, Md. 21921 | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

IMMEDIATE CAUSE (Final disease or condition resulting in death) → Lung Cancer
DUE TO (OR AS A CONSEQUENCE OF):

Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
a. DUE TO (OR AS A CONSEQUENCE OF):
b. DUE TO (OR AS A CONSEQUENCE OF):
c. DUE TO (OR AS A CONSEQUENCE OF):
d. DUE TO (OR AS A CONSEQUENCE OF):

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | | Approximate Interval Between Onset and Death
3 years | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA
OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. MANNER OF DEATH
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation
<input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M | | 28c. INJURY AT WORK?
<input type="checkbox"/> YES <input type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| 29a. CERTIFIER (Check only one)
<input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
<i>H. Farkas, M.D.</i> | | | | 29c. LICENSE NUMBER
D15314 | | 29d. DATE SIGNED (Month, Day, Year)
May 10, 1996 | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
Henry Farkas, M.D., Northern Chesapeake Hospice, 239 S. Bridge St., Elkton, MD 21921 | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
MAY 14 1996 | | | | 32. REGISTRAR'S SIGNATURE
<i>John A. ...</i> | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 687600, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 15557

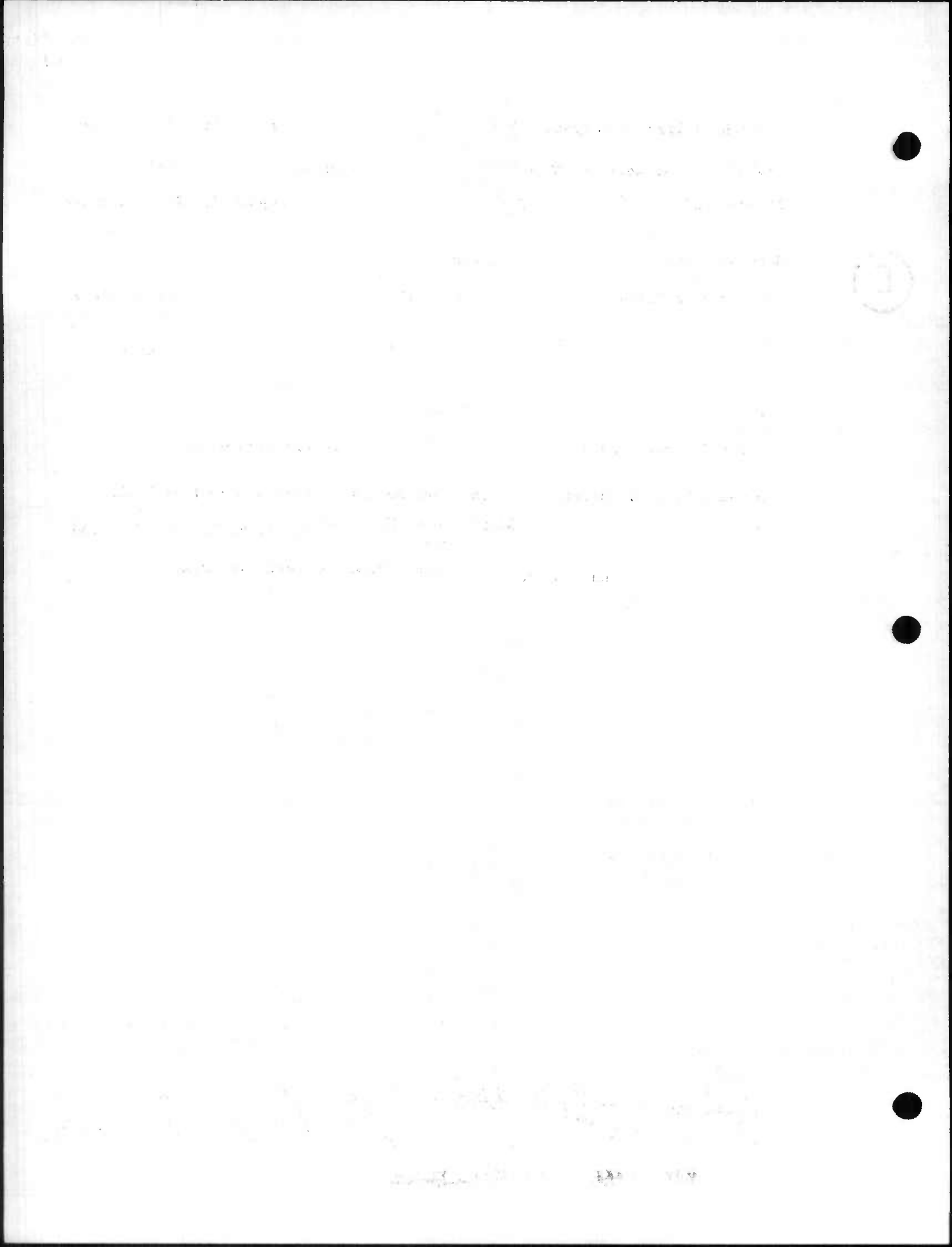
Certificate of Death

Reg. No.

| | | | | | | | | |
|---|--|--|--|--|--|--|---|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Michael Timothy Runyons, II | | | | 2. Date of Death
Month May Day 11 Year 1996 | | 3. Time of Death
0400 A | |
| | 4a. Facility Name (If not institution, give street and number)
RT 273 1 mile west of RT 545 | | | | 4b. City, Town, or Location of Death
Elkton | | 4c. County of Death
Cecil | |
| Funeral
Director | 5. Social Security Number
217-04-4187 | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday)
17 Yrs. | | 8. Date of Birth (Month, Day, Year)
August 8, 1978 | |
| | 9. Birthplace (State or Foreign Country)
Delaware | | 10a. State
Maryland | | 10b. County
Cecil | | 10c. City, Town or Location
Elkton | |
| To Be Completed by Funeral Director | 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 10e. Street and Number
38 Loveland Drive | | 10f. Zip Code
21921 | |
| | 10g. Citizen of What Country?
United States | | | | 11. Marital Status
<input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever In U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | |
| Physician
/Medical
Examiner | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | | 14. Race - American Indian, Black, White, etc.
Specify: White | | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 11 College (1-4or 5+) | |
| | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Student | | | | 16b. Kind of Business/Industry | | 17. Father's Name (First, Middle, Last)
Michael Timothy Runyons | |
| To Be Completed by Physician/Medical Examiner | 18. Mother's Name (First, Middle, Maiden Surname)
Terrie Lynn Quinn | | | | 19a. Informant's Name/Relationship (Type, Print)
Michael T. Runyons/Father | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
38 Loveland Drive, Elkton, Maryland 21921 | |
| | 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Gilpin Manor Memorial Park | | 20c. Location - City or Town, State
5-14-96 Elkton, Maryland | |
| To Be Completed by Physician/Medical Examiner | 21. Signature of Funeral Service Licensee
 | | | | 22. Name and Address of Facility
Hicks Home for Funerals, P.A.
103 W. Stockton St., Elkton, MD 21921-5521 | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. Acute head injury 20 to mva
Due to (or as a consequence of):

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of): | | | | Approximate Interval Between Onset and Death | | | |
| To Be Completed by Physician/Medical Examiner | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | |
| | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | |
| To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | 26. Piece of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) MVA | | | |
| | 27. Manner of Death
<input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | | | 28a. Date of Injury (Month, Day, Year)
5-11-96 | | | |
| To Be Completed by Physician/Medical Examiner | 28b. Time of Injury
0400 AM | | | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | |
| | 28d. Describe how Injury occurred
Passenger - Ejected From Vehicle | | | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
street | | | |
| To Be Completed by Physician/Medical Examiner | 28f. Location (Street and Number or Rural Route Number, City or Town, State)
273 1 mi west of 545 | | | | 29a. Certifier (Check only one)
<input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | |
| | 29b. Signature and title of certifier
 | | | | 29c. License number
D35674 | | | |
| To Be Completed by Physician/Medical Examiner | 29d. Date signed (Month, Day, Year)
5-11-96 | | | | 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)
Union Hospital 1000 Bow Street Elkton MD 21921 | | | |
| | 31. Date filed (Month, Day, Year)
5 MAY 14 1996 | | | | 32. Registrar's Signature
 | | | |



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 15558

Certificate of Death

Reg. No.

| | | | | | | | | | | | |
|---|---|---|--|--|--|---|--|--|---|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
THOMAS Joseph RINKLE | | | | 2. Date of Death
Month MAY Day 8 Year 1996 | | 3. Time of Death
8:37P | | | | |
| | 4a. Facility Name (If not institution, give street and number)
SOUTHERN MARYLAND HOSPITAL | | | | 4b. City, Town, or Location of Death
Clinton | | 4c. County of Death
PRINCE GEORGES | | | | |
| Funeral
Director | 5. Social Security Number
118-09-1456 | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)
77 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth (Month, Day, Year)
March 22, 1919 | | 9. Birthplace (State or Foreign Country)
New York | | |
| | Usual Residence of Decedent | | | | | | | | | | |
| 10e. State
Md. | | 10b. County
Prince George | | 10c. City, Town or Location
Suitland | | | | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | |
| 10e. Street and Number
5212 Morris Ave. Apt. 204 | | | | 10f. Zip Code
20746 | | 10g. Citizen of What Country?
U.S.A. | | | | | |
| 11. Marital Status
<input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
If Yes, Give Year or Dates: 1941-46 | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: White | | | | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 Collegia (1-4or 5+) 12 | | | | 18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Communication Analyst | | 16b. Kind of Business/Industry
Dept. of Defense | | | | | |
| 17. Father's Name (First, Middle, Last)
Edward P. Rinkle | | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Margaret F. Clancy | | | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
Lucille D. Mallard-Administrator | | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
2231 Colts Neck Rd. #314 Reston, Va. 22091 | | | | | | |
| 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Md. Veterans Cemetery | | Data
5/13/96 | | 20c. Location - City or Town, State
Cheltenham, Md. | | | | | |
| 21. Signature of Funeral Service Licensee
SKS. Smith | | | | 22. Name and Address of Facility
Lee Funeral Home
6633 Old Alexander Ferry Rd. Clinton, Md. | | | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. Bacterial pneumonia
Due to (or as a consequence of):
b. Chronic Obstructive Pulmonary Disease
Due to (or as a consequence of):
c. Respiratory Failure
Due to (or as a consequence of):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
3 weeks
7 to 9 years | | | | | | | | | | Approximate Interval Between Onset and Death | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Long stress, possible carcinoma | | | | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | |
| 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | | | |
| 27. Manner of Death
<input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier
John J. Sullivan | | | | | | | | | |
| 29c. License number
D 20824 | | 29d. Date signed (Month, Day, Year)
5/9/96 | | | | | | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
John J. Sullivan 4430 Penn. Ave. #18 Upper Marlboro, MD | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
MAY 15 1996 | | 32. Registrar's Signature
John J. Sullivan | | | | | | | | | |

Baltimore, Maryland 21215-0020
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", of items 23 and 25, show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

(F)

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 15559

Certificate of Death

Reg. No.

Physician
/Medical
ExaminerFuneral
Director

1. Decedent's Name (First, Middle, Last)

MARY L Rich

2. Date of Death

Month Day Year
MAY 7 1996

3. Time of Death

1:19 PM

4a. Facility Name (If not institution, give street and number)

Southern Maryland Hospital

4b. City, Town, or Location of Death

Clinton

4c. County of Death

Prince Georges

5. Social Security Number

220-22-6160

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

70

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

December 2, 1925

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Prince George's

10c. City, Town or Location

Brandywine

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

12711 Martin Road

10f. Zip Code

20613

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: Black

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

Collega (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Secretary

16b. Kind of Business/Industry

State Government

17. Father's Name (First, Middle, Last)

James W. Simms

18. Mother's Name (First, Middle, Maiden Summa)

Mary M. Chaney

19a. Informant's Name/Relationship (Type, Print)

Amos Rich- Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

12711 Martin Road Brandywine, Maryland 20613

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Maryland Veterans May 14, 1996

Date

20c. Location - City or Town, State

Cheltenham, Maryland

21. Signature of Funeral Service Licensee

Lloyd M. Estes

22. Name and Address of Facility

Adams Funeral Home Aquasco, Maryland 20608

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)ACUTE MYOCARDIAL INFARCTION
AND CARDIOGENIC FAILUREApproximate
Interval Between
Onset and Death

12 days

Due to (or as a consequence of):

ATHEROSCLEROTIC HEART DISEASE

Due to (or as a consequence of):

GENERALIZED ARTERIOSCLEROSIS

Due to (or as a consequence of):

DIABETES

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

SEVERE CARDIOMYOPATHY
CEREBRAL ANOXIA AND A NOXIC
ENCEPHALOPATHY
RESPIRATORY FAILURE

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending Investigation
6 ☐ Could not be determined28a. Date of Injury
(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)2 ☒ Medical ExaminerCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

Daniel M. Lee MD

29c. License number

D15789

29d. Date signed (Month, Day, Year)

5-7-96

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

7700 OLD BRANCH AVENUE
CLINTON, MD 20735DANIEL M. LEE MD
CLINTON, MD 20735

31. Date filed (Month, Day, Year)

MAY 14 1996

32. Registrar's Signature

Julia Davidson Randall

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 15560

Certificate of Death

Reg. No.

| | | | | | | | | | | |
|---|---|--|---|--|--|--|---|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
IRA HOYT ROBINETTE | | | | | | 2. Date of Death
Month Day Year
MAY 10 1996 | | 3. Time of Death
21:55 | |
| | 4a. Facility Name (If not institution, give street and number)
MEMORIAL HOSPITAL & MEDICAL CENTER | | | | | | 4b. City, Town, or Location of Death
CUMBERLAND | | 4c. County of Death
ALLEGANY | |
| Funeral
Director | 5. Social Security Number
212-38-5351 | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday)
92 Yrs. | | 8. Date of Birth (Month, Day, Year)
FEB 20 1904 | | 9. Birthplace (State or Foreign Country)
PA. | |
| | Usual Residence of Decedent | | | | | | | | | |
| E | 10a. State
MARYLAND | | 10b. County
ALLEGANY | | 10c. City, Town or Location
CUMBERLAND | | | | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | |
| | 10e. Street and Number
1524B OLDTOWNE MANOR | | | | 10f. Zip Code
21502 | | 10g. Citizen of What Country?
U.S.A. | | | |
| To Be Completed by Funeral Director | 11. Marital Status
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc.
Specify: WHITE | | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) Collega (1-4 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
DISTRICT EQUIPMENT SUPERVISOR MD.STATE HIGHWAY DEPT. | | | | 16b. Kind of Business/Industry | | | |
| To Be Completed by Physician/Medical Examiner | 17. Father's Name (First, Middle, Last)
FRANCIS W. ROBINETTE | | | | | | 18. Mother's Name (First, Middle, Maiden Surname)
LULA BELL IMES | | | |
| | 19a. Informant's Name/Relationship (Type, Print)
VERNA L. WILSON DAU. | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
14500 BALTIMORE PIKE CUMBERLAND MARYLAND 21502 | | | | | |
| Physician
/Medical
Examiner | 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
FELLOWSHIP CEMETERY MAY 13 1996 | | Data
MAY 13 1996 | | 20c. Location - City or Town, State
CENTERVILLE, PA. | | | |
| | 21. Signature of Funeral Service Licensee
<i>Dale L. Merritt</i> | | | | 22. Name and Address of Facility
MERRITT-ADAMS Funeral Home
404 DECATUR STREET CUMBERLAND MARYLAND 21502 | | | | | |
| To Be Completed by Physician/Medical Examiner | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. Acute Myocardial infarction
Dua to (or as a consequence of):
b. Pneumonia
Dua to (or as a consequence of):
c.
Dua to (or as a consequence of):
d. | | | | | | | | | |
| | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown

24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | | | | | |
| To Be Completed by Physician/Medical Examiner | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | | |
| | 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)
27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation
2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined
3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide
28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
28d. Describe how injury occurred
28e. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | | |
| To Be Completed by Physician/Medical Examiner | 29a. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | |
| | 29b. Signature and title of certifier
<i>[Signature]</i> MD | | 29c. License number
D 23371 | | 29d. Date signed (Month, Day, Year)
MAY 13, 96 | | | | | |
| State Registrar | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
DR. QAMAR ZAMAN, SUITE 102, 625 KENT AVE., CUMBERLAND, MD 21502 | | | | | | | | | |
| | 31. Date filed (Month, Day, Year)
MAY 13 1996 | | 32. Registrar's Signature
<i>[Signature]</i> | | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 15561

Certificate of Death

Reg. No.

| | | | | | | | | | | | | | | | |
|---|--|--------------------------------|--|---|--|---------------------------------|--------------------------------|--|--|--|---|---|---|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
JOHN L. REED | | | | 2. Date of Death
Month MAY 13 , Day 1996 Year | | | | 3. Time of Death
0019AM | | | | | | |
| | 4a. Facility Name (If not institution, give street and number)
MEMORIAL HOSPITAL | | | | 4b. City, Town, or Location of Death
CUMBERLAND | | | | 4c. County of Death
ALLEGANY | | | | | | |
| Funeral
Director | 5. Social Security Number
201-16-4504 | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday)
71 Yrs. | | If Under 1 Year
Months Days | | If Under 24 Hrs.
Hours Min. | | 8. Date of Birth
(Month, Day, Year)
Dec 23, 1924 | | 9. Birthplace (State or Foreign Country)
PA | | |
| | Usual Residence of Decedent | | | | | | | | | | | | | | |
| 10a. State
MD | | 10b. County
Allegany | | 10c. City, Town or Location
Cumberland | | | | | | 10d. Inside City Limits
1 <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | |
| 10e. Street and Number
12023 Kneisley Drive NE | | | | 10f. Zip Code
21502 | | | | 10g. Citizen of What Country?
USA | | | | | | | |
| 11. Marital Status
1 <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | | | 12. Was Decedent Ever in U.S. Armed Forces?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
If Yes, Give Year or Dates: WW II | | | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | | 14. Race - American Indian, Black, White, etc.
Specify: white | | | |
| 15. Decedent's Education
(Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (1-4or 5+) | | | | 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)
Retired Teacher | | | | 16b. Kind of Business/Industry
Allegany Co. School Sys | | | | | | | |
| 17. Father's Name (First, Middle, Last)
Harold E. Reed, Sr. | | | | | | | | 18. Mother's Name (First, Middle, Maiden Summa)
Keron J. (Lovell) | | | | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
Nancy S. Reed--wife | | | | | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
12023 Kneisley Drive NE; Cumberland, MD 21502 | | | | | | | |
| 20a. Method of Disposition
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Spring Hill Cemetery | | | | Date
05/16 | | 20c. Location - City or Town, State
Shippensburg, PA | | | | | |
| 21. Signature of Funeral Service Licensee
<i>James F. Scarpelli</i> | | | | | | | | 22. Name and Address of Facility
Scarpelli Funeral Home
Cumberland, MD 21502 | | | | | | | |
| 23a. Pertinent disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | | | | | | | | Approximate Interval Between Onset and Death | |
| Immediate Cause (Final disease or condition resulting in death) | | | | | | | | | | | | | | Immediate | |
| a. Ventricular Asystole
Due to (or as a consequence of): | | | | | | | | | | | | | | | |
| b. Myocardial Infarction
Due to (or as a consequence of): | | | | | | | | | | | | | | 1 hour | |
| c. Hypertension
Due to (or as a consequence of): | | | | | | | | | | | | | | 3 years | |
| d. | | | | | | | | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | | | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | | | |
| | | | | | | | | | | 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | |
| 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one)
Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | | | | | |
| 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation
2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined
3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how Injury occurred | | | | | |
| | | | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| 29a. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | 29b. Signature and title of certifier
<i>Dr. Anthony J. Bolling</i> | | | | 29c. License number
D17565 | | | | 29d. Date signed (Month, Day, Year)
May 14 1996
5-14-96 | | | |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)
DR. ANTHONY J. BOLLING 955 FREDERICK ST., CUMBERLAND, MD 21502 | | | | | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
MAY 15 1996 | | | | 32. Registrar's Signature
<i>Jabin Anderson-Randall</i> | | | | | | | | | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 96 15562
Certificate of Death

Reg. No.

Physician
/Medical
ExaminerFuneral
Director

| | | | | | | | |
|---|--|---|--|--|--------------------------------|--|--|
| 1. Decedent's Name (First, Middle, Last)
<i>Dorothy Avis Snyder</i> | | | | 2. Date of Death
Month <i>May</i> Day <i>10</i> Year <i>1996</i> | | 3. Time of Death
<i>2328</i> | |
| 4a. Facility Name (If not institution, give street and number)
<i>Washington County Hospital</i> | | | | 4b. City, Town, or Location of Death
<i>Hagerstown</i> | | 4c. County of Death
<i>Washington</i> | |
| 5. Social Security Number
<i>214-28-6025</i> | | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)
<i>64</i> Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth (Month, Day, Year)
<i>Oct. 5, 1931</i> | |
| 9. Birthplace (State or Foreign Country)
<i>Maryland</i> | | | | | | | |
| Usual Residence of Decedent | | | | | | | |
| 10a. State
<i>MD</i> | | 10b. County
<i>Washington</i> | | 10c. City, Town or Location
<i>Hagerstown</i> | | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | |
| 10e. Street and Number
<i>1008 Columbia Road</i> | | | | 10f. Zip Code
<i>21742</i> | | 10g. Citizen of What Country?
<i>U.S.A.</i> | |
| 11. Marital Status
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: <i>White</i> | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) <i>12</i> College (1-4 or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
<i>Homemaker</i> | | 16b. Kind of Business/Industry
<i>Home</i> | |
| 17. Father's Name (First, Middle, Last)
<i>John Howard Pearl</i> | | | | 18. Mother's Name (First, Middle, Maiden Surname)
<i>Avis Irene Hawbaker</i> | | | |
| 19a. Informant's Name/Relationship (Type, Print)
<i>Edwin E. Snyder/ Husband</i> | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
<i>1008 Columbia Road Hagerstown, MD 21742</i> | | | |
| 20a. Method of Disposition
<input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
<i>Smithsburg Crematory</i> | | Date
<i>5/13/96</i> | | 20c. Location - City or Town, State
<i>Smithsburg, Maryland</i> | |
| 21. Signature of Funeral Service Licensee
<i>Dennis L. Davis</i> | | | | 22. Name and Address of Facility
<i>Davis Funeral Home 12525 Bradbury Ave. Smithsburg, MD 21783</i> | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
Immediate Cause (Final disease or condition resulting in death)
e. <i>Mesenteric Thrombosis</i>
Due to (or as a consequence of):
b. <i>Atrial Fibrillation</i>
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.
Approximate Interval Between Onset and Death
<i>5 days</i>
<i>2 years</i> | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
<i>Carcinoma of kidney</i> | | | | | | | |
| 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | | | | | | |
| 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No | | | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input type="checkbox"/> No | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28d. Describe how injury occurred | | | |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | |
| 29b. Signature and title of certifier
<i>Dennis L. Davis</i> | | | | 29c. License number
<i>D 46231</i> | | 29d. Date signed (Month, Day, Year)
<i>May 11, 1996</i> | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
<i>D. Lai 370 Mill Street Hagerstown Md</i> | | | | | | | |
| 31. Date filed (Month, Day, Year)
<i>MAY 13 1996</i> | | | | 32. Registrar's Signature
<i>Jebia Shuck</i> | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transitBaltimore, Maryland 21215-0020
F
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 15563

Certificate of Death

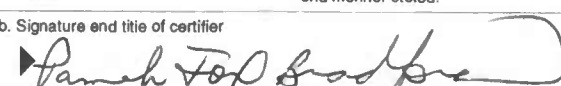
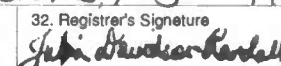
Reg. No.

| | | | | | | | | | |
|---|---|--|---|---|--|--|---|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
ROGER LEADY SNOOK | | | | 2. Date of Death
Month MAY Day 11 Year 1996 | | 3. Time of Death
06:15 AM | | |
| | 4a. Facility Name (If not institution, give street and number)
Washington County Hospital | | | | 4b. City, Town, or Location of Death
Hagerstown | | 4c. County of Death
Washington | | |
| Funeral
Director | 5. Social Security Number
215-18-1071 | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)
69 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth (Month, Day, Year)
July 15, 1926 | 9. Birthplace (State or Foreign Country)
Maryland | |
| | Usual Residence of Decedent | | | | | | | | |
| To Be Completed by Funeral Director | 10a. State
Maryland | 10b. County
Washington | 10c. City, Town or Location
Hagerstown | | | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | |
| | 10e. Street and Number
1053 Beechwood Drive | | | 10f. Zip Code
21742 | | 10g. Citizen of What Country?
U.S.A. | | | |
| | 11. Marital Status
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever In U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: White | | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 Years College (1-4or 5+) Sheet Metal Worker | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | | 16b. Kind of Business/Industry
Aircraft Manufacture | | | |
| | 17. Father's Name (First, Middle, Last)
Albert M. Snook | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Elta Turner | | | | |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print)
Jean L. Snook/Wife | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1053 Beechwood Drive, Hagerstown, MD 21742 | | | | |
| | 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Rest Haven Cemetery | | Date
May 14, 1996 | | 20c. Location - City or Town, State
Hagerstown, Maryland | | |
| | 21. Signature of Funeral Service Licensee
 | | | | 22. Name and Address of Facility
Douglas A. Fiery Funeral Home
1331 Eastern Blvd. North, Hagerstown, MD 21742 | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

e. RESPIRATORY FAILURE
Due to (or as a consequence of):
b. SEVERE CHRONIC OBSTRUCTIVE PULMONARY DISEASE
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Approximate Interval Between Onset and Death
MINUTES
YEARS | | | | | | | | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown | |
| | | | | | | | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation
<input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined
<input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | 29b. Signature and title of certifier
 | | 29c. License number
238822 | | 29d. Date signed (Month, Day, Year)
5/11/96 | |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)
PAMELA FOX BRADFORD, MD 1799 HOWELL RD HAGERSTOWN, MD 21740 | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
MAY 13 1996 | | | | 32. Registrar's Signature
 | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 15564

Certificate of Death

Reg. No.

| | | | | | | | | |
|---|--|--|---|--------------------------------|--|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Alma Sabina Ways Staubs | | | | 2. Date of Death
Month Day Year
May 9 1996 | | 3. Time of Death
5:15 am | |
| | 4a. Facility Name (If not institution, give street and number)
Residence: 275 Jackson Park Road | | | | 4b. City, Town, or Location of Death
Port Deposit | | 4c. County of Death
Cecil | |
| Funeral
Director | 5. Social Security Number
233-34-3618 | 6. Sex
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)
70 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth (Month, Day, Year)
Jan. 13, 1926 | | 9. Birthplace (State or Foreign Country)
West Virginia |
| | Usual Residence of Decedent | | | | | | | |
| To Be Completed by Funeral Director | 10a. State
Maryland | | 10b. County
Cecil | | 10c. City, Town or Location
Port Deposit | | 10d. Inside City Limits
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | |
| | 10e. Street and Number
275 Jackson Park Road | | | | 10f. Zip Code
21904 | | 10g. Citizen of What Country?
U.S.A. | |
| To Be Completed by Physician/Medical Examiner | 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: White | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) Ten Years | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Homemaker | | 16b. Kind of Business/Industry
Home | | | |
| To Be Completed by Physician/Medical Examiner | 17. Father's Name (First, Middle, Last)
Arthur Ways | | | | 18. Mother's Name (First, Middle, Maiden Summa)
Lila Whittington | | | |
| | 19a. Informant's Name/Relationship (Type, Print)
Vicki L. Singleton | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
16 North Main Street, Port Deposit, Maryland 21904 | | | |
| To Be Completed by Physician/Medical Examiner | 20a. Method of Disposition
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Pleasant View Memorial Gardens | | Date
5/13/96 | | 20c. Location - City or Town, State
Martinsburg, West Virginia | |
| | 21. Signature of Funeral Service Licensee
<i>Thomas M. Patterson Sr.</i> | | | | 22. Name and Address of Facility
Lee A. Patterson & Son Funeral Home
Perryville, Maryland 21903 | | | |
| To Be Completed by Physician/Medical Examiner | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. <i>Ruptured abdominal Aortic Aneurysm</i>
Due to (or as a consequence of):

b. _____
Due to (or as a consequence of):

c. _____
Due to (or as a consequence of):

d. _____

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | Approximate Interval Between Onset and Death
5 MONTHS |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |
| To Be Completed by Physician/Medical Examiner | 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |
| | 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| To Be Completed by Physician/Medical Examiner | 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide
5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| | 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| To Be Completed by Physician/Medical Examiner | 29a. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | |
| | 29b. Signature and title of certifier
<i>Smith</i> | | | | 29c. License number
D45344 | | 29d. Date signed (Month, Day, Year)
5/10/96 | |
| To Be Completed by Physician/Medical Examiner | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
20 CRAIGTOWN ROAD PERRYVILLE, MD 21903 | | | | | | | |
| | 31. Date filed (Month, Day, Year)
MAY 10 1996 | | | | 32. Registrar's Signature
<i>Julia Davidson-Rodell</i> | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

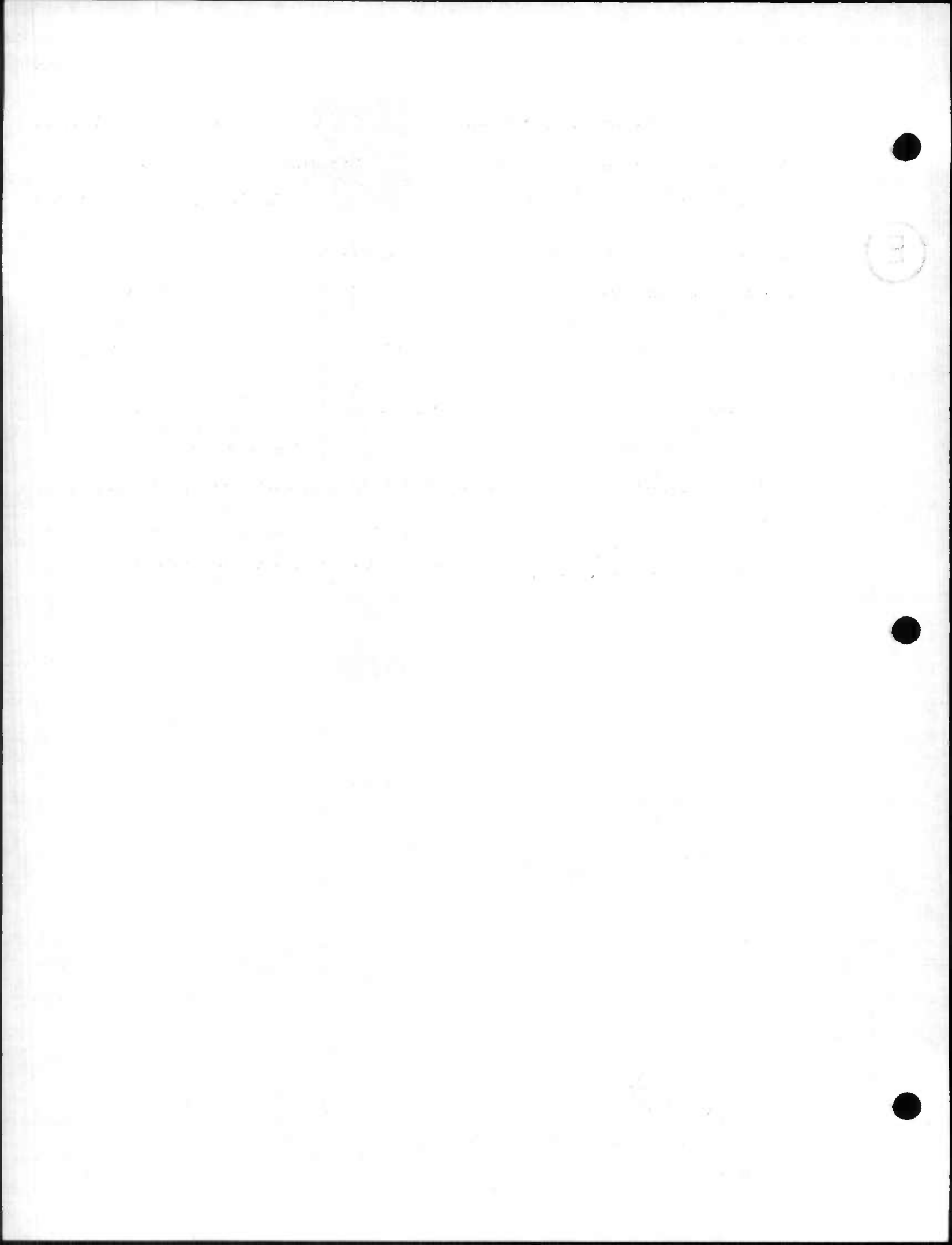
Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 15565

Certificate of Death

Reg. No.

| | | | | | | | | |
|---|---|-----------------------------|---|---|---|--|--|---|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Anna Elizabeth Speakman | | | | 2. Date of Death
Month May Day 12 Year 96 | | 3. Time of Death
12:30pm | |
| | 4e. Facility Name (If not institution, give street and number)
Union Hospital | | | | 4b. City, Town, or Location of Death
Elkton | | 4c. County of Death
Cecil | |
| Funeral
Director | 5. Social Security Number
213-38-5017 | | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)
95 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth (Month, Day, Year)
Sept. 4, 1900 | 9. Birthplace (State or Foreign Country)
Maryland |
| | Usual Residence of Decedent | | | | | | | |
| 10a. State
Maryland | | 10b. County
Cecil | | 10c. City, Town or Location
Elkton | | | 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 10e. Street and Number
2329 Blue Ball Road | | | | 10f. Zip Code
21921 | | 10g. Citizen of What Country?
USA | | |
| 11. Marital Status
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: White | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 8 College (1-4 or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Homemaker | | | 16b. Kind of Business/Industry | |
| 17. Father's Name (First, Middle, Last)
William T. Chidester | | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Sarah E. Smith | | | |
| 19a. Informant's Name/Relationship (Type, Print)
Ralph J. Speakman/Son | | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
2329 Blue Ball Road, Elkton, Maryland 21921 | | | |
| 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Union Cemetery | | Date
5-15-96 | | 20c. Location - City or Town, State
Union, Maryland | |
| 21. Signature of Funeral Service Licensee
Donna S. Hicks | | | | | 22. Name and Address of Facility
Hicks Home for Funerals, P.A.
103 W. Stockton St., Elkton, MD 21921-5521 | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. Pneumonia
Due to (or as a consequence of):
b. Aspiration
Due to (or as a consequence of):
c. Atrial Fibrillation
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
d. | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | |
| | | | | | | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | 28. Place of Death (Check only one)
Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation
<input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined
<input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | | 28a. Date of injury (Month, Day, Year) | | 28b. Time of injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| | | | 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) | | | 28d. Describe how injury occurred | | |
| | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | |
| 29b. Signature and title of certifier
Timothy J. Randall | | | | | 29c. License number
D33510 | | 29d. Date signed (Month, Day, Year)
5-13-96 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Timothy J. Randall | | | | | | | | |
| 31. Date filed (Month, Day, Year)
MAY 14 1996 | | | 32. Registrar's Signature
Lidia Davidson-Randall | | | | | |

Baltimore, Maryland 21215-0020

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 15566

Certificate of Death

Reg. No.

| | | | | | | | | |
|---|--|--|---|--|--|---|--|---|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Allen Lee Sheffield | | | | 2. Date of Death
Month 5 Day 7 Year 96 | | 3. Time of Death
1940 | |
| | 4a. Facility Name (If not institution, give street and number)
Dorchester General Hospital | | | | 4b. City, Town, or Location of Death
Cambridge | | 4c. County of Death
Dorchester | |
| Funeral
Director | 5. Social Security Number
217-30-7914 | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)
62 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth (Month, Day, Year)
11-27-33 | 9. Birthplace (State or Foreign Country)
Georgia |
| | Usual Residence of Decedent | | | | | | | |
| To Be Completed by Funeral Director | 10a. State
Maryland | | 10b. County
Dorchester | | 10c. City, Town or Location
East New Market | | | 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| | 10e. Street and Number
5919 Webster Avenue | | | | 10f. Zip Code
21631 | | 10g. Citizen of What Country?
U.S. | |
| | 11. Marital Status
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: Black | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 3 College (1-4or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Field-work | | | 16b. Kind of Business/Industry
Farmer | | |
| To Be Completed by Physician/Medical Examiner | 17. Father's Name (First, Middle, Last)
Alvin Lee Sheffield | | | | 18. Mother's Name (First, Middle, Maiden Surname)
ESSIE MOORE | | | |
| | 19a. Informant's Name/Relationship (Type, Print)
Lynette Turner | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
600 Greenwood Ave. Apt. 201 Cambridge, MD. 21613 | | | |
| | 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Bethel Cemetery | | 20c. Location - City or Town, State
5/11/96 Cambridge, MD. | | 20d. Date | |
| | 21. Signature of Funeral Service Licensee
Janelle C. Henry | | | | 22. Name and Address of Facility
HENRY FUNERAL HOME
510 Washington St Cambridge, Maryland 21613 | | | |
| Physician
/Medical
Examiner | 23a. Part I. Enter the disease, or complications that caused death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. Heart Failure
Due to (or as a consequence of):
b. Atherosclerotic Cardiomyopathy
Due to (or as a consequence of):
c. Interstitial Pulmonary Disease
Due to (or as a consequence of):
d. Peripheral Vascular Disease | | | | | | | Approximate Interval Between Onset and Death
2 weeks
2 years
2 years
1 Month |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | 23b. Did tobacco use contribute to the cause of death?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |
| | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| | 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | 26. Place of Death (Check only one)
Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |
| Medical Certification: To Be Completed by Physician/Medical Examiner | 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input type="checkbox"/> No | |
| | 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28d. Describe how injury occurred | | | | | |
| | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | 28e. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| | 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate. | 29b. Signature and title of certifier
William Bair | | | | 29c. License number
D4323P | | 29d. Date signed (Month, Day, Year)
5/7/96 | |
| | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
William Bair 19 Franklin St. Cambridge, MD 21613 | | | | | | | |
| State Registrar | 31. Date filed (Month, Day, Year)
MAY 10 1996 | | 32. Registrar's Signature
John Davidson Randall | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

96 15567

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
GEORGE WILLIAM STEVENSON | | | | 2. DATE OF DEATH
MONTH MAY DAY 2 YEAR 1996 | | 3. TIME OF DEATH
5:30 A. M. | |
| 4. SOCIAL SECURITY NUMBER
215-26-6990 | | 5. SEX
1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
64 YRS. | | 7. DATE OF BIRTH (Month, Day, Year)
OCT. 19, 1931 | |
| 9a. FACILITY NAME (If not institution, give street and number)
MEMORIAL HOSPITAL | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
CUMBERLAND | | 9c. COUNTY OF DEATH
ALLEGANY | |
| 10a. STATE
MARYLAND | | 10b. COUNTY
ALLEGANY | | 10c. CITY, TOWN OR LOCATION
CUMBERLAND | | 10d. INSIDE CITY LIMITS?
1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER
80 AUBURN AVENUE | | | | 10f. ZIP CODE
21502 | | 10g. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 11. MARITAL STATUS
1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO
IF YES, GIVE WAR OR DATES
1951 - 1955 | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify: WHITE | |
| 15. DECEDENT'S EDUCATION
(Specify only highest grade completed)
Elementary/Secondary (0-12) _____ College (1-4 or 5+) 1 | | 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.)
SALES REPRESENTATIVE | | 16b. KIND OF BUSINESS/INDUSTRY
ADVERTISING | | | |
| 17. FATHER'S NAME (First, Middle, Last)
JAMES G. STEVENSON | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
LAURA A. HOLLER | | | |
| 19a. INFORMANT'S NAME (Type/Print)
ELLEN (JENKINS) STEVENSON | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
80 AUBURN AVENUE - CUMBERLAND, MD 21502 | | | |
| 20a. METHOD OF DISPOSITION
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) _____ | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
M.S.V.C. - ROCKY GAP 5/6/96 | | 20c. LOCATION — City or Town, State
FLINTSTONE, MD | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
<i>Stendy D. Upchurch</i> | | | | 22. NAME AND ADDRESS OF FACILITY
GEORGE-UPCHURCH FUNERAL HOME, P.A.
202 GREENE ST., CUMBERLAND, MD 21502 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | | | | | | | |
| a. Acute Renal Failure
DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| b. Advanced Refractory Multiple Myeloma
DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| c. _____
DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| d. _____
DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| 23. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Chronic Obstructive Pulmonary Disease
Transitional CA of Bladder
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/> | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA
OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) _____ | | | | | |
| 27. MANNER OF DEATH
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation
2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined
3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M | | 28c. INJURY AT WORK?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one)
1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
<i>[Signature]</i> MD | | | | 29c. LICENSE NUMBER
D 23371 | | 29d. DATE SIGNED (Month, Day, Year)
May 2, 1996 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (Item 27) (Type, Print)
QAMAR ZAMAN, M.D., 625 KENT AVENUE, SUITE 102, CUMBERLAND, MD 21502 | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
MAY 07 1996 | | 32. REGISTRAR'S SIGNATURE
<i>[Signature]</i> | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 15568

Certificate of Death

Reg. No.

| | | | | | | | | | |
|---|---|---------------------------------------|---|---|---|--|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
MINNIE ELIZABETH SPANGLER | | | | 2. Date of Death
Month Day Year
May 5, 1996 | | 3. Time of Death
2:15 A | | |
| | 4a. Facility Name (If not institution, give street and number)
Memorial Hospital | | | | 4b. City, Town, or Location of Death
Cumberland | | 4c. County of Death
Allegany | | |
| Funeral
Director | 5. Social Security Number
218-48-9293 | | 6. Sex
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)
90 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth (Month, Day, Year)
Sep 14, 1905 | 9. Birthplace (State or Foreign Country)
WV | |
| | Usual Residence of Decedent | | | | | | | | |
| To Be Completed by Funeral Director | 10a. State
MD | 10b. County
Allegany | 10c. City, Town or Location
Cumberland | | | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | |
| | 10e. Street and Number
515 Caroline Street | | | 10f. Zip Code
21502 | | 10g. Citizen of What Country?
USA | | | |
| | 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: white | | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (1-4 or 5+) 12 | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Homemaker | | | 16b. Kind of Business/Industry
Own Home | | | |
| | 17. Father's Name (First, Middle, Last)
Robert T. Hare | | | | 18. Mother's Name (First, Middle, Maiden Summa)
Grace (Fawver) | | | | |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print)
William Spangler--son | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
515 Caroline Street; Cumberland, MD 21502 | | | | |
| | 20a. Method of Disposition
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Davis Memorial Cemetery | | Date
05/07 | | 20c. Location - City or Town, State
Cumberland, MD | | |
| | 21. Signature of Funeral Service Licensee
James F. Scarpelli | | | | 22. Name and Address of Facility
Scarpelli Funeral Home
Cumberland, MD 21502 | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
Immediate Cause (Final disease or condition resulting in death)
e. Chronic obstructive Pulmonary Disease
Due to (or as a consequence of):
f. Due to (or as a consequence of):
g. Due to (or as a consequence of):
h. Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last | | | | | | | | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Atherosclerotic Heart Disease | | | | | | | | |
| 23b. Did tobacco use contribute to the cause of death?
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | | | | | | | |
| 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | | | | | |
| 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one)
Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide
5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how Injury occurred | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| 29a. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | | |
| 29b. Signature and title of certifier
Guy Fiscus | | | | 29c. License number
D 12779 | | 29d. Date signed (Month, Day, Year)
May 6 1996 | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Dr. Guy Fiscus Memorial Hospital Medical Bldg. Cumberland, MD 21502 | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
MAY 06 1996 | | | | 32. Registrar's Signature
John A. Hurd | | | | | |

Baltimore, Maryland 21215-0020

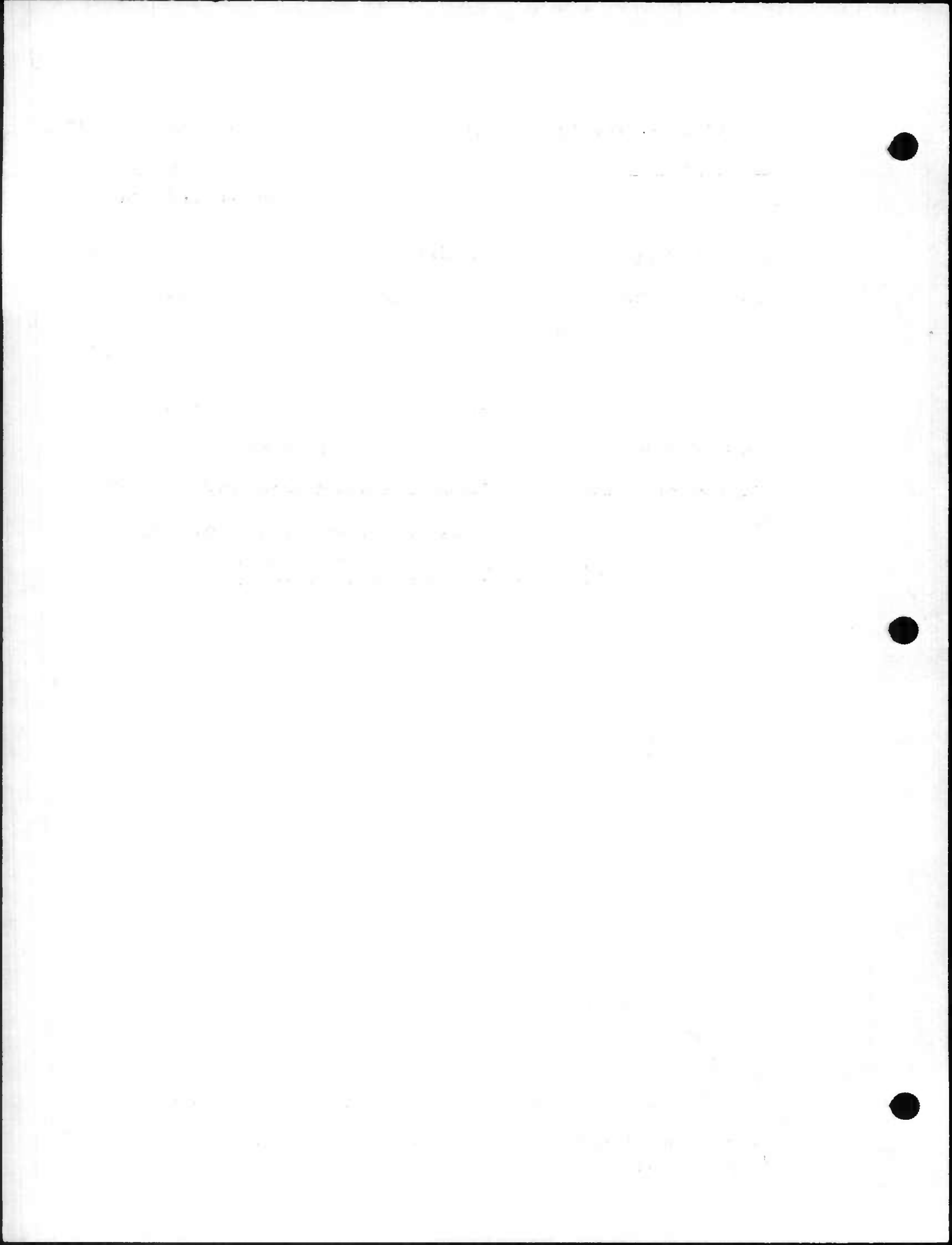
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner



96 15569

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|---|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
STANLEY L. SLIVIAK | | | | 2. DATE OF DEATH
MONTH MAY DAY 4 YEAR 1996 | | 3. TIME OF DEATH
6:15 A M | |
| 4. SOCIAL SECURITY NUMBER
210-05-8341 | | 5. SEX
1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
78 YRS. | | 7. DATE OF BIRTH (Month, Day, Year)
JUNE 5, 1917 | |
| 8. BIRTHPLACE (State or Foreign Country)
PENNSYLVANIA | | | | 9a. FACILITY NAME (If not institution, give street and number)
1120 SIMPSON AVE. | | 9b. CITY, TOWN OR LOCATION OF DEATH
LA VALE | |
| 9c. COUNTY OF DEATH
ALLEGANY | | | | 10a. STATE
MARYLAND | | 10b. COUNTY
ALLEGANY | |
| 10c. CITY, TOWN OR LOCATION
LA VALE | | | | 10d. INSIDE CITY LIMITS?
1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 10e. STREET AND NUMBER
1120 SIMPSON AVE. | |
| 10f. ZIP CODE
21502 | | | | 10g. CITIZEN OF WHAT COUNTRY?
USA | | | |
| 11. MARITAL STATUS
1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO
IF YES, GIVE WAR OR DATES
WW II KOREAN | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify:
WHITE | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (1-4 or 5+) 2 | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
SUPERVISOR | | 16b. KIND OF BUSINESS/INDUSTRY
GLASS | | | |
| 17. FATHER'S NAME (First, Middle, Last)
JOHN SLIVIAK | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
SALOMEA SLIVIAK | | | |
| 19a. INFORMANT'S NAME (Type/Print)
EVA SLIVIAK | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1120 SIMPSON AVE., LA VALE, MD 21502 | | | |
| 20a. METHOD OF DISPOSITION
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
SUNSET MEMORIAL PARK 5/7/96 | | 20c. LOCATION — City or Town, State
CUMBERLAND, MARYLAND | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
<i>[Signature]</i> | | | | 22. NAME AND ADDRESS OF FACILITY
HAFFER CHAPEL OF THE HILLS MORTUARY
1302 NATIONAL HWY. LA VALE, MD 21502 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | | a. MULTI VESSEL CAD | | | | Approximate interval Between Onset and Death
5 YEARS | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | b. SEVERE ISCHEMIC CARDIOMYOPATHY | | | | 2 YEARS | |
| | | c. DUE TO (OR AS A CONSEQUENCE OF): | | | | | |
| | | d. DUE TO (OR AS A CONSEQUENCE OF): | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | 24a. WAS AN AUTOPSY PERFORMED?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation
2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined
3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M | | 28c. INJURY AT WORK?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. CERTIFIER (Check only one)
1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
<i>[Signature]</i> | | | | 29c. LICENSE NUMBER
D6041 | | 29d. DATE SIGNED (Month, Day, Year)
May 5, 1996 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
TE WILLIAMS, MD MEMORIAL MED CTR, CUMBERLAND, MD 21502 | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
MAY 07 1996 | | | | 32. REGISTRAR'S SIGNATURE
<i>[Signature]</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

15570

Physician
/Medical
ExaminerFuneral
Director

| | | | | | | | |
|--|--|---|--|---|--|---|--|
| 1. Decedent's Name (First, Middle, Last)
MARGARET LORETTA SCHIVER | | | | 2. Date of Death
Month MAY Day 4 Year 1996 | | 3. Time of Death
2:00 AM | |
| 4a. Facility Name (If not institution, give street and number)
SACRED HEART HOSPITAL | | | | 4b. City, Town, or Location of Death
CUMBERLAND | | 4c. County of Death
ALLEGANY | |
| 5. Social Security Number
215 44 9155 | | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday)
91 | | 8. Date of Birth (Month, Day, Year)
JULY 20, 1904 | |
| 9. Birthplace (State or Foreign Country)
MARYLAND | | 10a. State
MARYLAND | | 10b. County
ALLEGANY | | 10c. City, Town or Location
FROSTBURG | |
| 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 10e. Street and Number
10513 BORDEN ROAD, NW | | 10f. Zip Code
21532 | | 10g. Citizen of What Country?
U.S. | |
| 11. Marital Status
<input type="checkbox"/> Navar Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: WHITE | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 11 College (1-4or 5+) 11 | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
COOK | | 16b. Kind of Business/Industry
RESTAURANT | | 17. Father's Name (First, Middle, Last)
CHARLES BLANK | |
| 18. Mother's Name (First, Middle, Maiden Summa)
MARY ORT | | 19a. Informant's Name/Relationship (Type, Print)
MILTON SCHIVER /SON | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
10513 BORDEN ROAD, NW, FROSTBURG, MD 21532 | | | |
| 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
FROSTBURG MEMORIAL PARK 5/6/96 | | 20c. Location - City or Town, State
FROSTBURG, MD 21532 | | 21. Signature of Funeral Service Licensee
<i>Maribou M. Sowers</i> | |
| 22. Name and Address of Facility
SOWERS FUNERAL HOME, P.A.
60 W. MAIN ST., FROSTBURG, MD 21532 | | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

a. Left lung atelectasis
Due to (or as a consequence of):
b. Cerebrovascular Accident
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Approximate Interval Between Onset and Death
2 weeks
2 weeks | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 28d. Describe how Injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier
<i>Thomas E. Chappell MD</i> | | 29c. License number
MD 35135 | | 29d. Date signed (Month, Day, Year)
MAY 6 1996 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Thomas E. Chappell MD Cumberland MD 21504 | | | | | | | |
| 31. Date filed (Month, Day, Year)
MAY 6 8 1996 | | 32. Registrar's Signature
<i>John D. Randall</i> | | | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

3

State
Registrar

96 15571

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
Grace Anna TEACH | | | | 2. DATE OF DEATH
MONTH DAY YEAR
MAY 9 1996 | | 3. TIME OF DEATH
10:10PM | |
| 4. SOCIAL SECURITY NUMBER
220-28-3447 | | 5. SEX
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
93 YRS. | | 7. DATE OF BIRTH (Month, Day, Year)
Nov. 1, 1902 | |
| 8. BIRTHPLACE (State or Foreign Country)
Maryland | | | | 9a. FACILITY NAME (If not institution, give street and number)
Ravenwood Lutheran Village | | 9b. CITY, TOWN OR LOCATION OF DEATH
Hagerstown | |
| 9c. COUNTY OF DEATH
WASHINGTON | | | | 10a. STATE
Maryland | | 10b. COUNTY
Washington | |
| 10c. CITY, TOWN OR LOCATION
Williamsport | | | | 10d. INSIDE CITY LIMITS?
1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 10e. STREET AND NUMBER
18 N. Vermont St. | |
| 10f. ZIP CODE
21795 | | | | 10g. CITIZEN OF WHAT COUNTRY?
USA | | 11. MARITAL STATUS
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify:
White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12) 8 College (1-4 or 5+) 8 | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
Roller | | 16b. KIND OF BUSINESS/INDUSTRY
Silk Label Manufacture | |
| 17. FATHER'S NAME (First, Middle, Last)
Carlton Christian Mentzer | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Anna Elizabeth Metcalf | | | |
| 19a. INFORMANT'S NAME (Type/Print)
J. Elwood Teach | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
13600 Paradise Dr. Hagerstown, MD 21742 | | | |
| 20a. METHOD OF DISPOSITION
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
Greentown Memorial Park 5/13 | | 20c. LOCATION — City or Town, State
Williamsport, MD 21795 | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
<i>M. J. M. Decker</i> | | | | 22. NAME AND ADDRESS OF FACILITY
OSBORNE FUNERAL HOME
P.O. Box # 348 Williamsport, MD 21795 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Dissecting aortic aneurysm</i>
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
a. DUE TO (OR AS A CONSEQUENCE OF):
b. DUE TO (OR AS A CONSEQUENCE OF):
c. DUE TO (OR AS A CONSEQUENCE OF):
d. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
<i>Chronic obstructive lung disease, severe</i>
<i>disorders,</i> | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA
OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | |
| 27. MANNER OF DEATH
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide
5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28c. INJURY AT WORK?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | 28d. DESCRIBE HOW INJURY OCCURED | | | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one)
1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
<i>Samuel Chaw</i> | | | | 29c. LICENSE NUMBER
036655 | | 29d. DATE SIGNED (Month, Day, Year)
3/10/96 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
1181 MT RETNA MD | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
MAY 10 1996 | | | | 32. REGISTRAR'S SIGNATURE
<i>J. Elwood Teach</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit form. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 15572

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Amelia Jean TAYLOR

2. Date of Death

May 11 1996

3. Time of Death

12:45 p.m.

4a. Facility Name (If not institution, give street and number)

Washington County Hospital

4b. City, Town, or Location of Death

Hagerstown

4c. County of Death

Washington

Funeral
Director

5. Social Security Number

232-13-9792

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

24 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

April 6, 1972

9. Birthplace (State or Foreign Country)

West Virginia

Usual Residence of Decedent

10a. State

Maryland

10b. County

Washington

10c. City, Town or Location

Hagerstown

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

420 West Franklin Street

10f. Zip Code

21740

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: white

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

0

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

homemaker

16b. Kind of Business/Industry

her own

17. Father's Name (First, Middle, Last)

William S. Pearrell

18. Mother's Name (First, Middle, Maiden Summa)

Barbara Jean Lanham

19a. Informant's Name/Relationship (Type, Print)

Robert L. Taylor, Jr.

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

420 W. Franklin St., Hagerstown, Md. 21740

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Rose Hill Cemetery 5-14-96

Date

20c. Location - City or Town, State

Hagerstown, Maryland

21. Signature of Funeral Service Licensee

Scott Minnich

22. Name and Address of Facility

MINNICH FUNERAL HOME

415 E. Wilson Blvd., Hagerstown, Md. 21740

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)Sequently list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

Respiratory Failure
Due to (or as a consequence of):
ARDS Adult Respiratory Distress Syndrome
Due to (or as a consequence of):
Cerebrovascular Pneumonia
Due to (or as a consequence of):
Advanced Acquired Immune Deficiency
Syndrome

Minutes
Days
Weeks
Years

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation
6 ☐ Could not be determined28a. Date of Injury
(Month, Day Year)28b. Time of
Injury28c. Injury at
Work?1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

Mark W. Galt

29c. License number

D31880

29d. Date signed (Month, Day, Year)

5/13/96

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MARTIN W. GALLAGHER, JR. MD 11110 Medical Campus B, Hagerstown, MD

31. Date filed (Month, Day, Year)

MAY 13 1996

32. Registrar's Signature

*John Davidson Kendall*State
Registrar

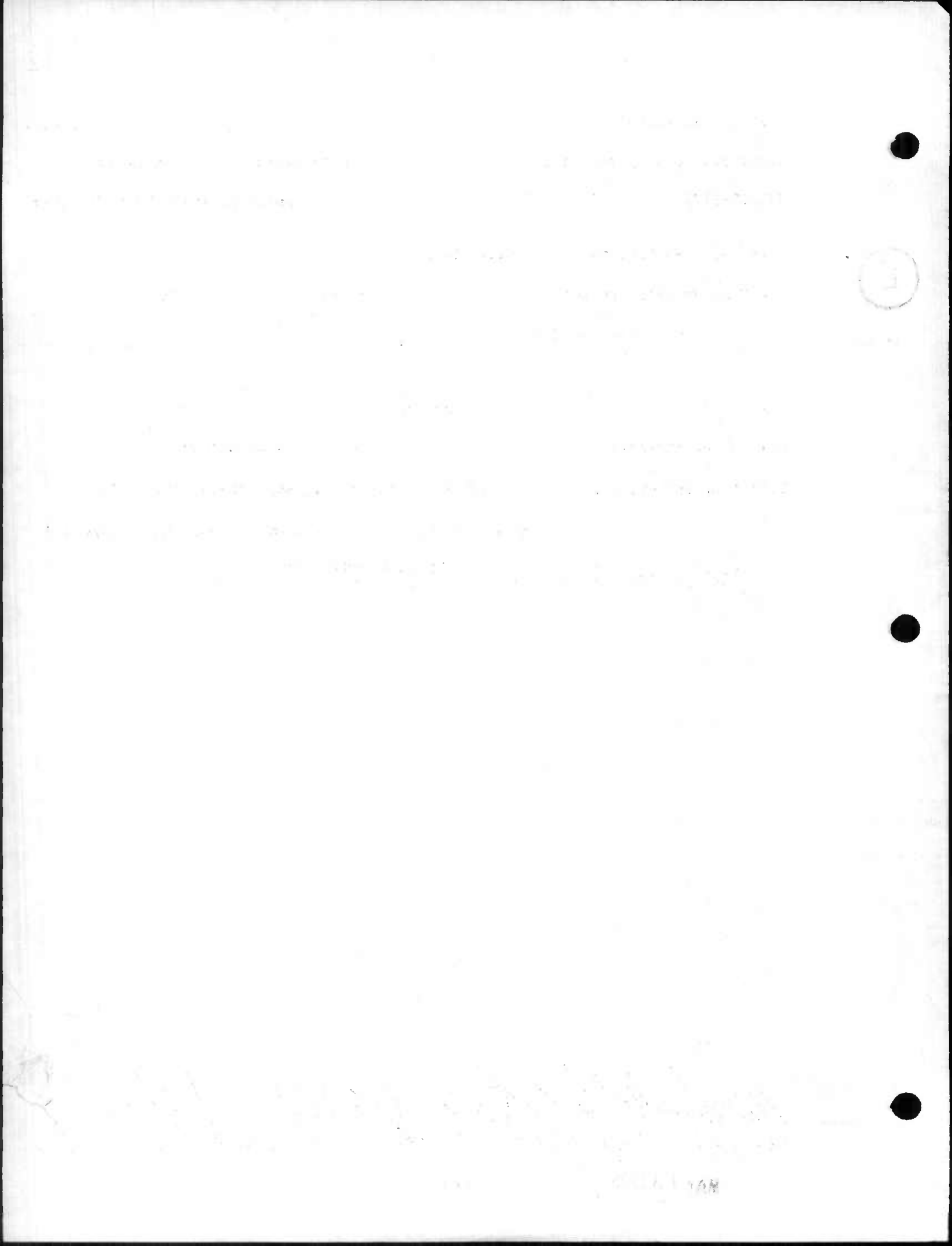
Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 15573

Certificate of Death

Reg. No.

| | | | | | | | | |
|--|--|---|---|--|--|--------------------------------|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
<i>Mary Ellen Taylor</i> | | | | 2. Date of Death
Month <i>MAY</i> Day <i>11</i> Year <i>1996</i> | | 3. Time of Death
<i>12:53 AM</i> | |
| | 4a. Facility Name (If not institution, give street and number)
<i>Southern Maryland Hospital</i> | | | | 4b. City, Town, or Location of Death
<i>Clinton</i> | | 4c. County of Death
<i>Prince George's</i> | |
| Funeral
Director | 5. Social Security Number
<i>212-24-4838</i> | | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)
<i>80</i> Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth (Month, Day, Year)
<i>June 5, 1915</i> | 9. Birthplace (State or Foreign Country)
<i>Maryland</i> |
| | 10a. State
<i>Maryland</i> | | 10b. County
<i>Prince George's</i> | | 10c. City, Town or Location
<i>Upper Marlboro</i> | | 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| To Be Completed by Funeral Director | 10e. Street and Number
<i>9910 Rosaryville Road</i> | | | | 10f. Zip Code
<i>20772</i> | | 10g. Citizen of What Country?
<i>U.S.A.</i> | |
| | 11. Marital Status
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: <i>White</i> | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) <i>7th</i> Collage (1-4 or 5+) <i>N/A</i> | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
<i>Homemaker</i> | | 16b. Kind of Business/Industry
<i>Home</i> | | | |
| | 17. Father's Name (First, Middle, Last)
<i>Benjamin Morton Tayman</i> | | | | 18. Mother's Name (First, Middle, Maiden Surname)
<i>Mary Elizabeth Taylor</i> | | | |
| | 19a. Informant's Name/Relationship (Type, Print)
<i>Kenneth Taylor</i> | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
<i>9910 Rosaryville Road Upper Marlboro, Md 20772</i> | | | |
| Physician
/Medical
Examiner | 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
<i>May 14, 1996</i>
<i>St. Thomas Episcopal Ch. Cem.</i> | | 20c. Location - City or Town, State
<i>Croom Maryland</i> | | | |
| | 21. Signature of Funeral Service Licensee
<i>Dr. F. Gitt</i> | | | | 22. Name and Address of Facility
<i>Lee Funeral Home, Inc.</i>
<i>6633 Old Alexandria Ferry Rd Clinton, Md 20735</i> | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. <i>Myocardial Infarction</i>
Due to (or as a consequence of):
b. <i>Arteriosclerotic Cardiovascular Disease</i>
Due to (or as a consequence of):
c. _____
Due to (or as a consequence of):
d. _____

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | Approximate interval Between Onset and Death
<i>hrs.</i>
<i>Yrs</i> |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |
| | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No |
| Medical Certification: To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| | 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | 28a. Date of injury (Month, Day Year) | | 28b. Time of injury
<i>M</i> | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input type="checkbox"/> No | |
| | | | 28a. Place of injury - At home, farm, street, factory, office building, etc. (Specify) | | 28d. Describe how injury occurred | | | |
| | | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| | 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | |
| State
Registrar | 29b. Signature and title of certifier
<i>Thomas L. Fieldson MD</i> | | | | 29c. License number
<i>DD1923</i> | | 29d. Date signed (Month, Day, Year)
<i>May 11, 1996</i> | |
| | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
<i>T.L. Fieldson MD 13600 Brandywine Rd, Brandywine, MD 20613</i> | | | | | | | |
| 31. Date filed (Month, Day, Year)
<i>MAY 15 1996</i> | | 32. Registrar's Signature
<i>John Davidson-Randall</i> | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

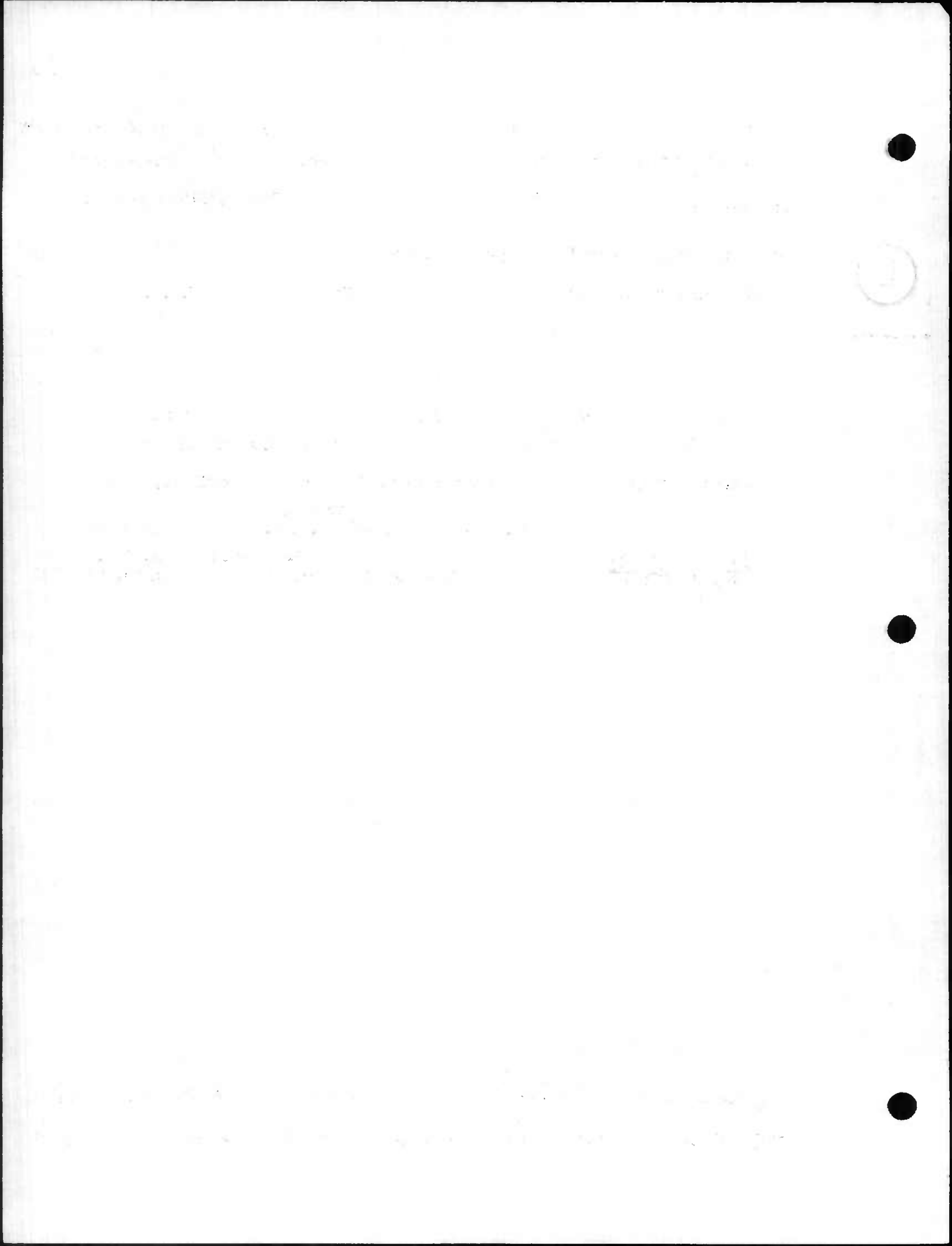
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



96 15574

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|---|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
<i>Verda Ethel Wilhide</i> | | | | 2. DATE OF DEATH
MONTH <i>May</i> DAY <i>13</i> YEAR <i>1996</i> | | 3. TIME OF DEATH
<i>10:05 P.M.</i> | |
| 4. SOCIAL SECURITY NUMBER
<i>219-54-0018</i> | | 5. SEX
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
<i>99</i> YRS. | | 7. DATE OF BIRTH
(Month, Day, Year)
<i>MAY 10, 1897</i> | |
| 8. FACILITY NAME (If not institution, give street and number)
<i>FAHRNEY-KEEDY MEMORIAL HOME</i> | | | | 9. CITY, TOWN OR LOCATION OF DEATH
<i>BOONSBORO</i> | | 10. COUNTY OF DEATH
<i>WASHINGTON</i> | |
| 11. STATE
<i>MARYLAND</i> | | | | 12. COUNTY
<i>WASHINGTON</i> | | 13. CITY, TOWN OR LOCATION
<i>BOONSBORO</i> | |
| 14. STREET AND NUMBER
<i>124 ORCHARD DRIVE</i> | | | | 15. ZIP CODE
<i>21713</i> | | 16. CITIZEN OF WHAT COUNTRY?
<i>U.S.A.</i> | |
| 17. MARITAL STATUS
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 18. WAS DECEDENT EVER IN U.S. ARMED FORCES?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 19. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 20. RACE — American Indian, Black, White, etc.
Specify:
<i>WHITE</i> | |
| 21. DECEDENT'S EDUCATION
(Specify only highest grade completed)
Elementary/Secondary (0-12) <i>1</i> College (1-4 or 5+) <i>1</i> | | 22. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.)
<i>HOMEMAKER</i> | | 23. KIND OF BUSINESS/INDUSTRY
<i>OWN HOME</i> | | | |
| 24. FATHER'S NAME (First, Middle, Last)
<i>CALEB LONG</i> | | | | 25. MOTHER'S NAME (First, Middle, Maiden Surname)
<i>FANNIE MULLENDORE</i> | | | |
| 26. INFORMANT'S NAME (Type/Print)
<i>A. MARIE CONRAD</i> | | | | 27. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
<i>11015 PIN OAK TERRACE, HAGERSTOWN, MD 21740</i> | | | |
| 28. METHOD OF DISPOSITION
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 29. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
<i>BOONSBORO CEMETERY</i> | | 30. DATE
<i>5/17/96</i> | | 31. LOCATION — City or Town, State
<i>BOONSBORO, MARYLAND</i> | |
| 32. SIGNATURE OF FUNERAL SERVICE LICENSEE
<i>John H. Bast Jr.</i> | | | | 33. NAME AND ADDRESS OF FACILITY
<i>BAST FUNERAL HOME 7606 Old National Pike Boonsboro, MD 21713</i> | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>a. cerebrovascular accident with</i>
DUE TO (OR AS A CONSEQUENCE OF):
b. <i>cerebral hemorrhage</i>
DUE TO (OR AS A CONSEQUENCE OF):
c. <i>hypertension</i>
DUE TO (OR AS A CONSEQUENCE OF):
d. <i>arrhythmia</i>
DUE TO (OR AS A CONSEQUENCE OF):
e. <i>sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST</i> | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
<i>Hypertension Cardiovascular Disease Stroke Arrhythmia</i>
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | |
| 34. WAS CASE REFERRED TO MEDICAL EXAMINER?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 35. PLACE OF DEATH (Check only one)
HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 36. MANNER OF DEATH
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation
<input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined
<input type="checkbox"/> Homicide | | 37. DATE OF INJURY (Month, Day, Year) | | 38. TIME OF INJURY
<i>M</i> | | 39. INJURY AT WORK?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 40. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 41. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| 42. CERTIFIER (Check only one)
<input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 43. SIGNATURE AND TITLE OF CERTIFIER
<i>Vasant Datta MD</i> | | | | 44. LICENSE NUMBER
<i>218019</i> | | 45. DATE SIGNED (Month, Day, Year)
<i>May 14, 1996</i> | |
| 46. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
<i>Dr. Vasant Datta 334 Mill Street, Hagerstown, Maryland 21740</i> | | | | | | | |
| 47. DATE FILED (Month, Day, Year)
<i>MAY 14 1996</i> | | | | 48. REGISTRAR'S SIGNATURE
<i>John H. Bast Jr.</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 15575

Certificate of Death

Reg. No.

| | | | | | | | | |
|--|--|--|---|--|--|--------------------------------|---|---|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Maurice Gordon White, Jr. | | | | 2. Date of Death
Month May Day 11 Year 1996 | | 3. Time of Death
12:00 PM | |
| | 4a. Facility Name (If not institution, give street and number)
1403 Pleasant View Rd. | | | | 4b. City, Town, or Location of Death
Adamstown | | 4c. County of Death
Frederick | |
| Funeral
Director | 5. Social Security Number
214-32-2745 | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)
60 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth (Month, Day, Year)
May 23, 1935 | 9. Birthplace (State or Foreign Country)
Maryland |
| | Usual Residence of Decedent
Maryland Frederick | | | | 10c. City, Town or Location
Frederick | | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | |
| To Be Completed by Funeral Director | 10a. State
Maryland | | 10b. County
Frederick | | 10f. Zip Code
21704 | | 10g. Citizen of What Country?
USA | |
| | 10e. Street and Number
4229 Araby Church Rd. | | 11. Marital Status
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
If Yes, Give Year or Dates: 1960-1962 | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (1-4or 5+) | | 18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Mail Handler | | 14. Race - American Indian, Black, White, etc.
Specify: White | | 16b. Kind of Business/Industry
Mail Service | |
| | 17. Father's Name (First, Middle, Last)
Maurice Gordon White, Sr. | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Naomi Roxy Pearson | | | |
| Physician
/Medical
Examiner | 19a. Informant's Name/Relationship (Type, Print)
Betty White - wife | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
4229 Araby Church Rd., Frederick, MD 21704 | | | |
| | 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Resthaven Memorial Gardens | | 20c. Location - City or Town, State
Frederick, Maryland | | 21. Signature of Funeral Service Licensee
Kuan H. Berger | |
| | 22. Name and Address of Facility
Stauffer Funeral Home | | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
Acute myocardial infarction | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| | 23c. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) Frederick | |
| Medical Certification: To Be Completed by Physician/Medical Examiner | 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| | 28d. Describe how Injury occurred | | 28e. Place of Injury - At home, term, street, tectory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | |
| | 29b. Signature and title of certifier
Robert S. Hughes | | 29c. License number
DD 5111 | | 29d. Date signed (Month, Day, Year)
5/13/96 | | 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)
Dr. Robert S. Hughes, M.D. / 700 Montclair Ave. / Frederick, Md. 21701 | |
| | 31. Date filed (Month, Day, Year)
MAY 14 1996 | | 32. Registrar's Signature
John Andrew Randall | | | | | |

Baltimore, Maryland 21215-0020

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

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3

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 15576

Certificate of Death

Reg. No.

| | | | | | | | | | |
|---|---|---|--|---|--|--|--|---|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Robert Glen Whitener | | | | 2. Date of Death
Month May Day 12 Year 1996 | | 3. Time of Death
9:41 PM | | |
| | 4a. Facility Name (If not institution, give street and number)
3827 Greenmount Church Road | | | | 4b. City, Town, or Location of Death
Hampstead | | 4c. County of Death
Carroll | | |
| Funeral
Director | 5. Social Security Number
238-09-8471 | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)
80 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth (Month, Day, Year)
May 12, 1916 | | 9. Birthplace (State or Foreign Country)
North Carolina | |
| | Usual Residence of Decedent | | | | | | | | |
| To Be Completed by Funeral Director | 10a. State
Maryland | 10b. County
Carroll | 10c. City, Town or Location
Hampstead | | | 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | |
| | 10e. Street and Number
3827 Greenmount Church Road | | | 10f. Zip Code
21074 | | 10g. Citizen of What Country?
USA | | | |
| | 11. Marital Status
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: WW II | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: White | | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 7 College (1-4or 5+) | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Machinist | | 16b. Kind of Business/Industry
Martin Marietta | | | |
| | 17. Father's Name (First, Middle, Last)
Daniel Holloway Whitener | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Minnie Agnes Price | | | | |
| | 19a. Informant's Name/Relationship (Type, Print)
Mary Katherine Whitener | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
3827 Greenmount Church Rd, Hampstead, MD 21074 | | | | |
| | 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Lake View Memorial Park | | Date
15/15 | | 20c. Location - City or Town, State
Sykesville, MD | | |
| | 21. Signature of Funeral Service Licensee
 | | | | 22. Name and Address of Facility
Eline Funeral Home
934 S Main St, Hampstead, MD 21074 | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. metastatic prostate cancer
Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last | | | | | | | | Approximate Interval Between Onset and Death
1 1/2 years |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | |
| | | | | | | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | |
| | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | |
| | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier
Brad D. Lerner MD | | | | | | | |
| | | 29c. License number
034608 | | 29d. Date signed (Month, Day, Year)
5/14/96 | | | | | |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)
Brad D. Lerner MD 7505 051st Dr. Suite 508 Towson, MD 21204 | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
MAY 15 1996 | | 32. Registrar's Signature
 | | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

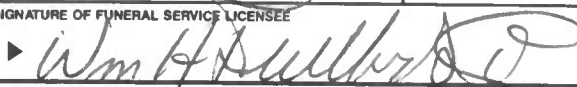

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

96 15577

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | |
|---|--|--|--|---|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
ELIZABETH A. WARD | | | | 2. DATE OF DEATH
MONTH DAY YEAR
May 3, 1996 | | | | 3. TIME OF DEATH
4:00 A M | |
| 4. SOCIAL SECURITY NUMBER
234-76-4759 | | 5. SEX
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
90 YRS. | | 7. DATE OF BIRTH
(Month, Day, Year)
Feb 22, 1906 | | 8. BIRTHPLACE (State or Foreign Country)
MD | |
| 9a. FACILITY NAME (If not institution, give street and number)
CUMBERLAND NURSING HOME | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
CUMBERLAND | | | | 9c. COUNTY OF DEATH
ALLEGANY | |
| RESIDENCE OF DECEDENT | | | | | | | | | |
| 10a. STATE
WV | | 10b. COUNTY
Mineral | | 10c. CITY, TOWN OR LOCATION
Piedmont | | | | 10d. INSIDE CITY LIMITS?
1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER
27 Green Street | | | | 10f. ZIP CODE
26750 | | | | 10g. CITIZEN OF WHAT COUNTRY?
USA | |
| 11. MARITAL STATUS
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | | | 14. RACE — American Indian, Black, White, etc.
Specify: white | |
| 15. DECEDENT'S EDUCATION
(Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (1-4 or 5+) 12 | | | | 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.)
Homemaker | | | | 16b. KIND OF BUSINESS/INDUSTRY
Own Home | |
| 17. FATHER'S NAME (First, Middle, Last)
Aden Grove | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Ida (Kooken) | | | | | |
| 19a. INFORMANT'S NAME (Type/Print)
Kenneth V. Ward | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
80 Maple Avenue; Keyser, WV 26726 | | | | | |
| 20a. METHOD OF DISPOSITION
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
Philos Cemetery | | | | 20c. LOCATION — City or Town, State
05/06 Westernport, MD | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
 | | | | 22. NAME AND ADDRESS OF FACILITY
Fredlock Funeral Home
Piedmont, WV 26750 | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Cerebrovascular accident
DUE TO (OR AS A CONSEQUENCE OF):
b. Aspiration Pneumonia
DUE TO (OR AS A CONSEQUENCE OF):
c. Metastatic Breast Cancer
DUE TO (OR AS A CONSEQUENCE OF):
d.
Approximate interval between Onset and Death
7 days
3 days
11 months | | | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Hypertension | | | | | | | | 24a. WAS AN AUTOPSY PERFORMED?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 27. MANNER OF DEATH
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation
2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined
3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M | | 28c. INJURY AT WORK?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| | | | | 28d. DESCRIBE HOW INJURY OCCURRED | | | | 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. CERTIFIER (Check only one)
1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | 29b. SIGNATURE AND TITLE OF CERTIFIER
Huma Shauil M.D. | | | | 29c. LICENSE NUMBER
D46346 | |
| | | | | 29d. DATE SIGNED (Month, Day, Year)
5/6/96 | | | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
HUMASHAKIL, 625 KENT AVENUE SUITE 304, CUMBERLAND, MD 21502 | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
MAY 06 1996 | | | | 32. REGISTRAR'S SIGNATURE
 | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



(2)



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 15578

Certificate of Death

Reg. No.

| | | | | | | | | | | | | |
|--|---|---------------------------------------|--|---|---|--|--|---|--|---|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
JAMES WALTER WIGGER | | | | 2. Date of Death
Month 02 Day 1996 Year | | | | 3. Time of Death
06 37 AM | | | |
| | 4a. Facility Name (If not Institution, give street and number)
MEMORIAL HOSPITAL | | | | 4b. City, Town, or Location of Death
CUMBERLAND | | | | 4c. County of Death
ALLEGANY | | | |
| Funeral
Director | 5. Social Security Number
214 34 1729 | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday)
58 Yrs. | | 8. Data of Birth (Month, Day, Year)
Jul 2, 1937 | | 9. Birthplace (State or Foreign Country)
MD | | | |
| | Usual Residence of Decedent | | | | | | | | | | | |
| To Be Completed by Funeral Director | 10a. State
MD | | 10b. County
ALLEGANY | | 10c. City, Town or Location
CUMBERLAND | | | | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | |
| | 10e. Street and Number
710 N. Mechanic Street | | | | 10f. Zip Code
21502 | | | | 10g. Citizen of What Country?
USA | | | |
| | 11. Marital Status
<input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
If Yes, Give Year or Dates: 1956-1958 | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | | 14. Race - American Indian, Black, White, etc.
Specify: white | | | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (1-4 or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Maintenance | | | | 16b. Kind of Business/Industry
Cumberland Housing Auth | | | |
| | 17. Father's Name (First, Middle, Last)
John Francis Wigger | | | | 18. Mother's Name (First, Middle, Maiden Summa)
Leona (Hartsock) | | | | | | | |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print)
Janet Payne--sister | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
12012 Bedford Road; Cumberland, MD 21502 | | | | | | | |
| | 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Rocky Gap Veterans Cem. | | Data
05/06 | | 20c. Location - City or Town, State
Flintstone, MD | | | | | |
| | 21. Signature of Funeral Service Licensee
 | | | | 22. Name and Address of Facility
Scarpelli Funeral Home
Cumberland, MD 21502 | | | | | | | |
| | 23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. Myocardial Infarction
Due to (or as a consequence of):
b. Hypertensive Cardiovascular Disease
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | | | | Approximate Interval Between Onset and Death
2 minutes

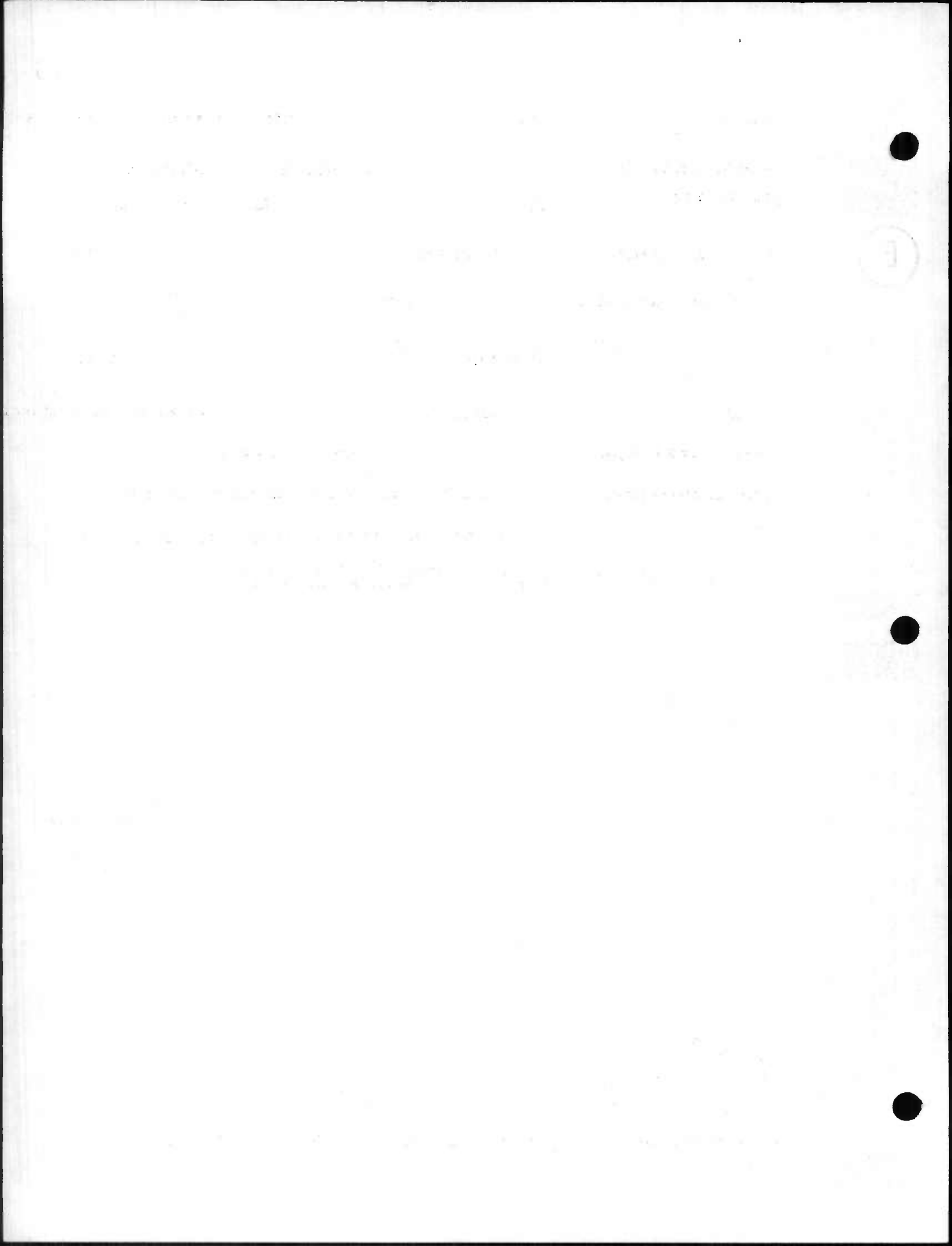
unknown | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | 23b. Did tobacco use contribute to the cause of death?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | |
| | | | | | | | | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input checked="" type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input type="checkbox"/> No | | 28d. Describe how injury occurred | | | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | 29b. Signature and title of certifier
 | | 29c. License number
012779 | | 29d. Date signed (Month, Day, Year)
5/6/96 | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
DR W G FISCUS 500 MEMORIAL AVE CUMBERLAND, MD 21502 | | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
MAY 06 1996 | | | | 32. Registrar's Signature
 | | | | | | | | |

Baltimore, Maryland 21215-0020

perm. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.



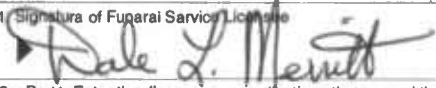
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.


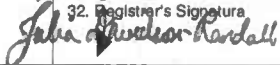
96 15579

| | | | | | | | | |
|--|--|---|--|---|---|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
JAMES LANNON WINTERS | | | | 2. Date of Death
Month MAY Day 13 Year 1996 | | 3. Time of Death
1720 PM | |
| | 4a. Facility Name (If not institution, give street and number)
SACRED HEART HOSPITAL | | | | 4b. City, Town, or Location of Death
CUMBERLAND | | 4c. County of Death
ALLEGANY | |
| Funeral
Director | 5. Social Security Number
218-24-1778 | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)
66 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth (Month, Day, Year)
JAN 7 1930 | | 9. Birthplace (State or Foreign Country)
MARYLAND |
| | 10a. State
PA. | | 10b. County
BEDFORD | | 10c. City, Town or Location
BEDFORD | | 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 10e. Street and Number
RFD#3 BOX#229F | | | | 10f. Zip Code
15522 | | 10g. Citizen of What Country?
U.S.A. | | |
| 11. Marital Status
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
If Yes, Give Year or Dates: 1950-1953 | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: WHITE | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (1-4or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
BETHLEHEM STEEL CO. | | 16b. Kind of Business/Industry
REPAIR YARD/LABORER | | |
| 17. Father's Name (First, Middle, Last)
WILLIAM HOMER WINTERS | | | | 18. Mother's Name (First, Middle, Maiden Surname)
EDNA WINTERS | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
IRENE WINTERS WIFE | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
RFD#3 BOX#229F BEDFORD PA. 15522 | | | | |
| 20a. Method of Disposition
<input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
ROCKY GAP VET. CEMETERY MAY 16 1996 FLINTSTONE RFD MD. | | 20c. Location - City or Town, State | | |
| 21. Signature of Funeral Service Licensee
 | | | | 22. Name and Address of Facility
MERRITT-ADAMS FUNERAL HOME
404 DECATUR STREET CUMBERLAND MARYLAND | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. RESPIRATORY FAILURE
Due to (or as a consequence of):
b. METASTATIC ADENOCARCINOMA OF THE LUNG
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | | Approximate interval Between Onset and Death
ONE HOUR

ONE YEAR |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
ESOPHAGEAL CARCINOMA

CONGESTIVE HEART FAILURE | | | | | | 23b. Did tobacco use contribute to the cause of death?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | |
| 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28. Place of Death (Check only one)
Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input type="checkbox"/> No | | 28d. Describe how Injury occurred |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier
 | | 29c. License number
033417 (md) | | 29d. Date signed (Month, Day, Year)
MAY 14, 1996 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
JAMES R. MOEN, MD 1068 NATIONAL HIGHWAY LA VALE, MD 21502 | | | | | | | | |
| 31. Date filed (Month, Day, Year)
MAY 14 1996 | | | | 32. Registrar's Signature
 | | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

State
Registrar

(E)

96 15580

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
Martha H. Yerkes | | | | 2. DATE OF DEATH
MONTH DAY YEAR
May 13 1996 | | 3. TIME OF DEATH
3:55 AM | |
| 4. SOCIAL SECURITY NUMBER
221-50-1286 | | 5. SEX
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
94 YRS. | | 7. DATE OF BIRTH (Month, Day, Year)
November 18 1901 | |
| 9a. FACILITY NAME (If not Institution, give street and number)
Calvert Manor Health Care Center | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
Rising Sun | | 9c. COUNTY OF DEATH
Cecil | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE
Maryland | | 10b. COUNTY
Cecil | | 10c. CITY, TOWN OR LOCATION
Rising Sun | | 10d. INSIDE CITY LIMITS?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 10e. STREET AND NUMBER
1881 Telegraph Road | | | | 10f. ZIP CODE
21911 | | 10g. CITIZEN OF WHAT COUNTRY?
United States | |
| 11. MARITAL STATUS
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (8-12) College (1-4 or 5+)
4 | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
School Teacher | | 16b. KIND OF BUSINESS/INDUSTRY
Board of Education
Cecil Co. Public Schools | | | |
| 17. FATHER'S NAME (First, Middle, Last)
Henry Henderson | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Jane Ann Steele | | | |
| 19a. INFORMANT'S NAME (Type/Print)
Marsha C. Knowles | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1833 Brubaker Run Road, Lancaster, PA 17603 | | | |
| 20a. METHOD OF DISPOSITION
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
North East Methodist Cemet. | | DATE
5/15 | | 20c. LOCATION — City or Town, State
North East, Maryland | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
 | | | | 22. NAME AND ADDRESS OF FACILITY
Crouch Funeral Home
127 South Main Street, North East, MD 21901 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | | a. Cardiac decompensation | | | | | |
| | | b. D.S.C.V.D. | | | | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | c. DUE TO (OR AS A CONSEQUENCE OF): | | | | | |
| | | d. DUE TO (OR AS A CONSEQUENCE OF): | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA
OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation
2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined
3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M | | 28c. INJURY AT WORK?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| | | 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. CERTIFIER (Check only one)
1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
 | | | | 29c. LICENSE NUMBER
D-11115 | | 29d. DATE SIGNED (Month, Day, Year)
5-13-96 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
Neil Taylor Jr MD P.O. 459 Rising Sun, MD 21901 | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
MAY 14 1996 | | 32. REGISTRAR'S SIGNATURE
 | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 15581

Physician
/Medical
ExaminerFuneral
Director

1. Decedent's Name (First, Middle, Last)

STEVE J. ANTKOWIAK

2. Date of Death

Month Day Year
MAY 18, 1996

3. Time of Death

5:20PM

4a. Facility Name (If not institution, give street and number)

819 S. BELNORD AVE.

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

N/A

5. Social Security Number

216-10-6960

8. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

84 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
SEPT. 2, 1911

9. Birthplace (State or Foreign Country)

POLAND

Usual Residence of Decedent

10e. State

MD.

10b. County

N/A

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

819 S. BELNORD AVE.

10f. Zip Code

21224

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give Year or Dates: WWII

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

8

College (1-4 or 5+)

17. Father's Name (First, Middle, Last)

JOHN ANTKOWIAK

18. Mother's Name (First, Middle, Maiden Summa)

PELAGIA

19a. Informant's Name/Relationship (Type, Print)

STELLA PATTON

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

227 S. ROBINSON ST. BALTO. MD 21224

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

ST. STANISLAUS CEM.

Date

MAY 20 1996

20c. Location - City or Town, State

BALTO. CO. MD.

21. Signature of Funeral Service Licensee

Thomas J. Skarda J.

22. Name and Address of Facility

SKARDA F.H.

2829 HUDSON ST.

BALTO., MD. 21224

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Acute Myocardial Infarction

Due to (or as a consequence of):

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Atrial Fibrillation

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ NoHospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA26. Place of Death (Check only one) Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending Investigation2 ☐ Accident 6 ☐ Could not be determined3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29e. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Thomas J. Skarda MD

29c. License number

D16619

29d. Date signed (Month, Day, Year)

May 20, 1996

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

C. VERGARA-SOARES 98 N. BROADWAY ST. BALTO. MD. 21218

31. Date filed (Month, Day, Year)

MAY 28 1996

32. Registrar's Signature

Davidson-Randall

State Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

96 15582

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
Mary Isabelle Ayd | | | | 2. DATE OF DEATH
MONTH DAY YEAR
May 24 1996 | | 3. TIME OF DEATH
11:35 p.m. M | |
| 4. SOCIAL SECURITY NUMBER
215-07-8515 | | 5. SEX
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
82 YRS. | | 7. DATE OF BIRTH (Month, Day, Year)
February 20, 1914 | |
| 8. BIRTHPLACE (State or Foreign Country)
Maryland | | | | 9a. CITY, TOWN OR LOCATION OF DEATH
Abingdon | | 9c. COUNTY OF DEATH
Harford Co. | |
| 9b. FACILITY NAME (If not institution, give street and number)
2902 Byron Court | | | | | | | |
| 10a. STATE
Maryland | | 10b. COUNTY
Harford Co. | | 10c. CITY, TOWN OR LOCATION
Abingdon | | 10d. INSIDE CITY LIMITS?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 10e. STREET AND NUMBER
2902 Byron Court | | | | 10f. ZIP CODE
21009 | | 10g. CITIZEN OF WHAT COUNTRY?
United States | |
| 11. MARITAL STATUS
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12) 12
College (1-4 or 5+) College | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
Homemaker | | 16b. KIND OF BUSINESS/INDUSTRY
Own Home | | | |
| 17. FATHER'S NAME (First, Middle, Last)
Francis Ryan | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Margaret Edell | | | |
| 19a. INFORMANT'S NAME (Type/Print)
James D. Ayd/ Son | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
2902 Byron Court Abingdon, Maryland 21009 | | | |
| 20a. METHOD OF DISPOSITION
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
Most Holy Redeemer Cemetery 5/28/96 | | 20c. LOCATION — City or Town, State
Baltimore, Maryland | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
Brian A. Willem | | | | 22. NAME AND ADDRESS OF FACILITY
Leonard J. Ruck Funeral Home, Inc.
5305 Harford Road Baltimore, Maryland 21214 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
IMMEDIATE CAUSE (Final disease or condition resulting in death) → Cerebrovascular Accident - Brain Stem
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST
a. Generalized Arteriosclerosis 15+ yrs
b. Hypertension 20+ yrs
c.
d. | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
END Stage Renal Disease & Hypertensive Nephropathy
Chronic Obstructive Pulmonary Disease
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/> | | | | 24a. WAS AN AUTOPSY PERFORMED?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA
OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation
2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined
3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 28c. INJURY AT WORK?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. CERTIFIER (Check only one)
1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
Gordon Walker, MD | | | | 29c. LICENSE NUMBER
D13118 | | 29d. DATE SIGNED (Month, Day, Year)
May 25, 1996 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
Gordon Walker, M.D. Good Samaritan Hospital 5610 Loch Raven Blvd. Baltimore, Md. 21239 | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
MAY 28 1996 | | | | 32. REGISTRAR'S SIGNATURE | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 15583

| | | | | | | | | | | |
|--|---|--|---|--|--|--|--|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
PATSY A ASTORE | | | | 2. Date of Death
Month Day Year
MAY 24, 1996 | | | | 3. Time of Death
12:12 P | |
| | 4a. Facility Name (If not institution, give street and number)
THE JOHNS HOPKINS HOSPITAL | | | | 4b. City, Town, or Location of Death
BALTIMORE CITY | | | | 4c. County of Death
N/A | |
| Funeral
Director | 5. Social Security Number
216-14-4281 | | 6. Sex
1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 7. Age (In yrs. last birthday)
79 Yrs. | | 8. Date of Birth (Month, Day, Year)
7-16; 1916 | | 9. Birthplace (State or Foreign Country)
Pennsylvania | |
| | Usual Residence of Decedent | | | | | | | | | |
| To Be Completed by Funeral Director | 10a. State
Maryland | | 10b. County
N/A | | 10c. City, Town or Location
Baltimore | | | | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| | 10e. Street and Number
4524 Weitzel Ave. | | | | 10f. Zip Code
21214 | | 10g. Citizen of What Country?
U.S.A. | | | |
| | 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc.
Specify: White | | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) College (1-4 or 5+)
12 | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Retired Master Sgt. | | | 16b. Kind of Business/Industry
U. S. Army | | |
| | 17. Father's Name (First, Middle, Last)
Frank Astore | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Aurora Prezioso | | | | | |
| | 19a. Informant's Name/Relationship (Type, Print)
Rose T. Astore (Wife) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
4524 Weitzel Ave. Baltimore, Maryland 21214 | | | | | |
| | 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Lake View Mem. Cemetery | | Data
5-28-96 | | 20c. Location - City or Town, State
Finksburg, Maryland | | | |
| | 21. Signature of Funeral Service Licensee
Wallace S. Brody Jr. | | | | 22. Name and Address of Facility
Leonard J. Ruck, Inc. 5305 Harford Rd. Baltimore, Md. 21214 | | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. Left middle cerebral artery stroke one day
Due to (or as a consequence of):
b. embolus from heart one day
Due to (or as a consequence of):
c. atrial fibrillation two years
Due to (or as a consequence of):
d. hypertension ten years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | | | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
severe peripheral vascular disease
three vessel coronary artery disease | | | | | | | | | |
| Physician
/Medical
Examiner | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | | | | | | | |
| | 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | |
| | 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | |
| | 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation
2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined
3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | |
| | 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| Medical Certification: To Be Completed by Physician/Medical Examiner | 29a. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | |
| | 29b. Signature and title of certifier
Rafat Bannert MD | | | | 29c. License number
N-4312 | | 29d. Date signed (Month, Day, Year)
May 24, 1996 | | | |
| | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
RAJAT BANNERTI M.D.
608 NORTH WOLFE STREET
BALTIMORE, MD | | | | | | | | | |
| State Registrar | 31. Date filed (Month, Day, Year)
MAY 28 1996
John [Signature] | | | | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Certificate of Death

Reg. No.

| | | | | | |
|---|--|--|--|--------------------------------|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
CATHERINE | | 2. Data of Death
Month MAY Day 17 Year 1996 | | 3. Time of Death
2350 P |
| | 4a. Facility Name (if not institution, give street and number)
CHURCH HOME & HOSPITAL | | 4b. City, Town, or Location of Death
BALTIMORE | | 4c. County of Death
N/A |
| Funeral
Director | 5. Social Security Number
213-80-6481 | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (in yrs. last birthday)
23 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. |
| | 8. Date of Birth (Month, Day, Year)
MARCH 26, 1973 | | 9. Birthplace (State or Foreign Country)
MD. | | |
| To Be Completed by Funeral Director | Usual Residence of Decedent | | | | |
| | 10a. State
MD. | 10b. County
N/A | 10c. City, Town or Location
BALTIMORE | | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |
| | 10e. Street and Number
2045 GOUGH ST. | | 10f. Zip Code
21231 | | 10g. Citizen of What Country?
U.S.A. |
| | 11. Marital Status
<input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |
| | 14. Race - American Indian, Black, White, etc.
Specify: WHITE | | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 9 College (1-4or 5+) | | |
| | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
DISABLED | | 16b. Kind of Business/Industry
N/A | | |
| | 17. Father's Name (First, Middle, Last)
ROBERT W. ARBOGAST JR. | | 18. Mother's Name (First, Middle, Maiden Summa)
MARIE PRINGLE | | |
| | 19. Informant's Name/Relationship (Type, Print)
ROBERT W. ARBOGAST | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
11 EBBING CT. ESSEX MD. 21221 | | |
| | 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
HOLLY HILL CEM. | | Date MAY 21 1996 |
| | 20c. Location - City or Town, State
BALTO. - MD. | | 21. Signature of Funeral Service Licensee
Thomas J. Skarda Jr. | | |
| 22. Name and Address of Facility
HOFFMAN SKARDA F.H. | | 3218 HUDSON ST. BALTO., MD. 21224 | | | |
| Physician
/Medical
Examiner | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

CARDIAC ARRHYTHMIA
Due to (or as a consequence of):

Due to (or as a consequence of):

Due to (or as a consequence of):

Due to (or as a consequence of): | | | | |
| | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | | | |
| | 24a. Was an autopsy performed?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | |
| | 25. Was case referred to medical examiner?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | |
| | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input checked="" type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | |
| | 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accidental <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | |
| | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input type="checkbox"/> No | | 28d. Describe how injury occurred |
| | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | |
| | 29a. Certifier (Check only one)
<input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | |
| | 29b. Signature and title of certifier
Am Dixon | | 29c. License number
O.C.M.E | | 29d. Date signed (Month, Day, Year)
MAY 18, 1996 |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
111 Penn Street, Baltimore, Maryland 21201 | | | | | |
| State
Registrar | 31. Data filed (Month, Day, Year)
MAY 28 1996 | | 32. Registrar's Signature
Davidson | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 15585

Certificate of Death

Reg. No.

| | | | | | | | | | | | |
|---|--|---------------------------------|---|---|--|--|---|---|---|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
LILLIAN R. ADAMS | | | | | | 2. Date of Death
Month MAY Day 26 Year 1996 | | 3. Time of Death
6:30AM | | |
| | 4a. Facility Name (If not institution, give street and number)
Northwest Hospital Center | | | | | | 4b. City, Town, or Location of Death
Randallstown | | 4c. County of Death
Baltimore | | |
| Funeral
Director | 5. Social Security Number
203-14-8041 | | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday)
87 Yrs. | | 8. Date of Birth (Month, Day, Year)
June 20, 1908 | | 9. Birthplace (State or Foreign Country)
Pennsylvania | | |
| | Usual Residence of Decedent | | | | | | | | | | |
| 10a. State
Maryland | | 10b. County
Baltimore | | 10c. City, Town or Location
Towson | | | | 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | |
| 10e. Street and Number
23 Acorn Circle Apt. 301 | | | | 10f. Zip Code
21286 | | | | 10g. Citizen of What Country?
United States | | | |
| 11. Marital Status
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc.
Specify: Caucasian | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) College (1-4or 5+)
1 year | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
School Teacher | | | | 16b. Kind of Business/Industry
Baltimore City School | | | |
| 17. Father's Name (First, Middle, Last)
Ralph L. Miller | | | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Lois Townsley | | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
Ralph L. Adams | | | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
3126 Brookmede Road Ellicott City, MD 21042 | | | | | |
| 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Woodlawn Cemetery | | | Date
May 30, 1996 | | 20c. Location - City or Town, State
Woodlawn, Maryland | | |
| 21. Signature of Funeral Service Licensee
Joseph Du Kellner | | | | | | 22. Name and Address of Facility
Loring Byers Funeral Directors, Inc.
8728 Liberty Road Randallstown, Maryland 21133 | | | | | |
| 23a. Part I: Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
Intra cerebral hemorrhage
Due to (or as a consequence of):

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Due to (or as a consequence of):

Due to (or as a consequence of):

Due to (or as a consequence of): | | | | | | | | | | Approximate Interval Between Onset and Death
6 days | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | | |
| | | | | | | | | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one)
Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation
<input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined
<input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | |
| | | | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | 29b. Signature and title of certifier
A. J. IMPERIAL, Jr. | | | | 29c. License number
844505 | | 29d. Date signed (Month, Day, Year)
MAY 26, 1996 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
A. J. IMPERIAL, Jr. - NWHC | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
MAY 28 1996 | | | | 32. Registrar's Signature
John Davidson-Randall | | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 15586

Certificate of Death

Reg. No.

| | | | | | | | | | |
|---|---|---|---|--|---|---|--|---|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Constance Adele Auer | | | | 2. Date of Death
Month Day Year
May 24, 1996 | | 3. Time of Death
6:30 PM | | |
| | 4a. Facility Name (If not institution, give street and number)
2702 Summerview Way, Unit 203 | | | | 4b. City, Town, or Location of Death
Annapolis | | 4c. County of Death
Anne Arundel | | |
| Funeral
Director | 5. Social Security Number
028-16-0268 | | 6. Sex
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday)
78 Yrs. | | 8. Date of Birth (Month, Day, Year)
DEC 3, 1917 | | |
| | 9. Birthplace (State or Foreign Country)
New York | | 10a. State
Florida | | 10b. County
Brevard | | 10c. City, Town or Location
Barefoot Bay | | |
| To Be Completed by Funeral Director | 10d. Inside City Limits
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 10e. Street and Number
714 N. Gladiolus Drive | | 10f. Zip Code
32976-7164 | | 10g. Citizen of What Country?
USA | | |
| | 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: White | | |
| To Be Completed by Physician/Medical Examiner | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) College (1-4 or 5+)
5+ | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Teacher | | 16b. Kind of Business/Industry
Public High School | | 17. Father's Name (First, Middle, Last)
Seymour Jesse Baum | | |
| | 18. Mother's Name (First, Middle, Maiden Surname)
Anne Margaret Lynch | | 19a. Informant's Name/Relationship (Type, Print)
Harold Sterling Auer/Spouse | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
714 N. Gladiolus Dr. Barefoot Bay, FL 32976-7164 | | 20a. Method of Disposition
1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | |
| To Be Completed by Physician/Medical Examiner | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Metro Crematory, Inc. 5/25/96 | | 20c. Location - City or Town, State
Baltimore, MD | | 21. Signature of Funeral Service Licensee
George E. MacNabb | | 22. Name and Address of Facility
Cremation Society of Maryland, Inc.
299 Frederick Rd. Baltimore, MD 21228 | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. Lung Cancer
Due to (as a consequence of):

b.
Due to (or as a consequence of):

c.
Due to (or as a consequence of):

d. | | Approximate Interval Between Onset and Death
6m | | 23b. Did tobacco use contribute to the cause of death?
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | |
| To Be Completed by Physician/Medical Examiner | 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide
5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | |
| | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how Injury occurred | | |
| To Be Completed by Physician/Medical Examiner | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | 29a. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier
Stanley Watkins | | |
| | 29c. License number
DO8118 | | 29d. Date signed (Month, Day, Year)
5/25/96 | | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
STANLEY WATKINS 900 BRISTOL AVE ANNAPOLIS MD 21401 | | 31. Date filed (Month, Day, Year)
MAY 28 1996 | | |
| 32. Registrar's Signature
[Signature] | | 33. Registrar's Title
[Signature] | | 34. Registrar's Name
[Signature] | | 35. Registrar's Address
[Signature] | | 36. Registrar's Phone
[Signature] | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 96 15587

Certificate of Death

Reg. No.

| | | | | | | | | |
|--|---|---|--|--|---|--|--|---|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Delores Allen | | | | 2. Date of Death
Month May Day 24th Year 1996 | | 3. Time of Death
5:30 AM | |
| | 4a. Facility Name (If not institution, give street and number)
LIBERTY MEDICAL CENTER | | | | 4b. City, Town, or Location of Death
BALTIMORE | | 4c. County of Death
N/A | |
| Funeral
Director | 5. Social Security Number
217-24-3310 | | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)
65 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth (Month, Day, Year)
Jan. 9, 1931 | 9. Birthplace (State or Foreign Country)
Maryland |
| | Usual Residence of Decedent | | | | | | | |
| 10a. State
MD | | 10b. County
N/A | | 10c. City, Town or Location
Baltimore | | | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | |
| 10e. Street and Number
4304 1/2 Norfolk Avenue | | | | 10f. Zip Code
21207 | | 10g. Citizen of What Country?
USA | | |
| 11. Marital Status
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever In U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: Black | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12th College (1-4 or 5+) | | | | 18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Conveyor Operator | | 16b. Kind of Business/Industry
Distributor | | |
| 17. Father's Name (First, Middle, Last)
Unknown | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Sarah Frey | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
Joyce Toler - daughter | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
303 B. Melvin Avenue, Baltimore, MD 21228 | | | | |
| 20a. Method of Disposition
<input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Metro Crematory | | Date
5/24 | | 20c. Location - City or Town, State
Baltimore, Maryland | | |
| 21. Signature of Funeral Service Licensee
Leroy O. Dyett Jr. | | | | 22. Name and Address of Facility
LEROY O. DYETT & SON FUNERAL HOME, P.A.
4600 LIBERTY HEIGHTS AVENUE, BALTO. 21207 | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
e. metastatic LUNG cancer
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. | | | | | | | | Approximate Interval Between Onset and Death |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
ANEMIA
COPD | | | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown | | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | 24e. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 26. Place of Death (Check only one)
Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier
Terance L. Ambrose | | 29c. License number
D37223 | | 29d. Date signed (Month, Day, Year)
May 24th 1996 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Terance L. Ambrose, Liberty Medical Center, Baltimore, MD | | | | | | | | |
| 31. Date filed (Month, Day, Year)
MAY 28 1996 | | | | 32. Registrar's Signature
John Davidson | | | | |

Baltimore, Maryland 21215-0020
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 15588

Certificate of Death

Reg. No.

| | | | | | | | | | |
|--|--|---|---|---|--|--|--|---|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
BRIAN F. ARNOLD | | | | 2. Date of Death
Month Day Year
MAY 25 1996 | | 3. Time of Death
1:30 A | | |
| | 4a. Facility Name (If not institution, give street and number)
5500 QUARANTINE RD. | | | | 4b. City, Town, or Location of Death
BALTIMORE | | 4c. County of Death
N/A | | |
| Funeral
Director | 5. Social Security Number
216-76-1525 | | 6. Sex
1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | 7. Age (In yrs. last birthday)
32 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth
(Month, Day, Year)
Oct. 18, 1963 | 9. Birthplace (State or Foreign Country)
Maryland | |
| | Usual Residence of Decedent | | | | | | | | |
| To Be Completed by Funeral Director | 10a. State
Md. | 10b. County
Anne Arundel | 10c. City, Town or Location
Glen Burnie | | | | 10d. Inside City Limits
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | |
| | 10e. Street and Number
604 Washington Avenue | | 10f. Zip Code
21060 | | 10g. Citizen of What Country?
U.S.A. | | | | |
| | 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: White | | |
| | 15. Decedent's Education
(Specify only highest grade completed)
Elementary/Secondary (0-12) Collage (1-4 or 5+)
12 | | 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)
Mill Operator | | 16b. Kind of Business/Industry
U.S. Gypsum Co. | | | | |
| | 17. Father's Name (First, Middle, Last)
Millard J. Arnold | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Dorothy Mooney | | | | |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print)
Lisa M. Arnold (Spouse) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
604 Washington Avenue Glen Burnie, Maryland 21061 | | | | |
| | 20a. Method of Disposition
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Glen Haven Cemetery | | Date
May 29, 1996 | 20c. Location - City or Town, State
Glen Burnie, Maryland | | | |
| | 21. Signature of Funeral Service Licensee
 | | | | 22. Name and Address of Facility
Witzke Funeral Homes, Inc.
1630 Edmondson Avenue Catonsville, Maryland | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. COMPRESSION ASPHYXIA
Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | |
| 24a. Was an autopsy performed?
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | |
| 25. Was case referred to medical examiner?
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) SCENE | | | | | | | |
| 27. Manner of Death
1 <input type="checkbox"/> Natural 2 <input checked="" type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide
5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year)
Found 5 25 96 | | 28b. Time of Injury
1230 A M | | 28c. Injury at Work?
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how Injury occurred
TRAPPED IN CONVEYOR BELT | |
| 29a. Certifier (Check only one)
1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated.
2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier
 | | 29c. License number
O.C.M.E | | 29d. Date signed (Month, Day, Year)
MAY 25, 1996 | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
MARYANN BRUCKNER 111 Penn Street, Baltimore, Maryland 21201 | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
MAY 28 1996 | | | | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

The Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completed by the funeral director, page 2 should be detached for use as the burial-transit permit.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene
Certificate of Death

96 15589

Reg. No.

| | | | | | | | | | | |
|---|--|---------------------------------|---|--|--|--|--|--|---|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Tony Appolonia | | | | | 2. Date of Death
Month Day Year
May 25 1996 | | | 3. Time of Death
9:10 AM | |
| | 4a. Facility Name (If not institution, give street and number)
301 S. Taylor Ave | | | | | 4b. City, Town, or Location of Death
N/A | | | 4c. County of Death
Baltimore | |
| Funeral
Director | 5. Social Security Number
215-01-8129 | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)
82 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth (Month, Day, Year)
Mar 15, 1914 | | 9. Birthplace (State or Foreign Country)
Maryland | |
| | Usual Residence of Decedent | | | | | | | | | |
| 10a. State
Md | | 10b. County
Baltimore | | 10c. City, Town or Location
N/A | | | | 10d. Inside City Limits
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | |
| 10e. Street and Number
301 S. Taylor Ave | | | | 10f. Zip Code
21221 | | | 10g. Citizen of What Country?
USA | | | |
| 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No
If Yes, Give Year or Dates: 1941 | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc.
Specify: White | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 6 College (1-4or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Tavern Owner | | | 16b. Kind of Business/Industry
Tavern | | | |
| 17. Father's Name (First, Middle, Last)
Unknown | | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Delphine Merletti | | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
Tony S. Appolonia / son | | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
301 S. Taylor Ave Baltimore, Md 21221 | | | | | |
| 20a. Method of Disposition
1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Metro Crematory | | Date
5/26/96 | | 20c. Location - City or Town, State
Catonsville, Md | | | |
| 21. Signature of Funeral Service Licensee
<i>Anthony C. Connelly</i> | | | | | 22. Name and Address of Facility
Connelly Funeral Home of Dundalk
7110 Sollers Point Rd 21222 | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death, or do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

<div style="display: flex; justify-content: space-between;"> <div style="width: 60%;"> <p>Immediate Cause (Final disease or condition resulting in death)</p> <p>a. <i>Acute intracerebral hemorrhage</i></p> <p>Due to (or as a consequence of):</p> <p>b. Due to (or as a consequence of):</p> <p>c. Due to (or as a consequence of):</p> <p>d. Due to (or as a consequence of):</p> </div> <div style="width: 35%; text-align: center;"> <p>Approximate Interval Between Onset and Death</p> <p>Immediate</p> </div> </div> | | | | | | | | | | |
| <div style="display: flex; justify-content: space-between;"> <div style="width: 65%;"> <p>Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.</p> </div> <div style="width: 30%;"> <p>23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input checked="" type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown</p> </div> </div> | | | | | | | | | | |
| <div style="display: flex; justify-content: space-between;"> <div style="width: 65%;"> <p>24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</p> </div> <div style="width: 30%;"> <p>24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p> </div> </div> | | | | | | | | | | |
| <div style="display: flex; justify-content: space-between;"> <div style="width: 30%;"> <p>25. Was case referred to medical examiner?
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No</p> </div> <div style="width: 70%;"> <p>28. Place of Death (Check only one)
Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify)</p> </div> </div> | | | | | | | | | | |
| 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation
2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined
3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how Injury occurred | |
| | | | 28e. Place of Injury - At home, farm, street, tectory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. Certifier (Check only one)
1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | | | |
| 29b. Signature and title of certifier
<i>J. Crossan O'Donovan, M.D.</i> | | | | | 29c. License number
007632 | | 29d. Date signed (Month, Day, Year)
MAY 25, 1996 | | | |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)
J. Crossan O'Donovan, M.D. 2112 Dundalk Ave Baltimore, Md 21222 | | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
MAY 28 1996 | | | | | 32. Registrar's Signature
<i>J. Crossan O'Donovan</i> | | | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0020 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. The Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 15590

Certificate of Death

Reg. No.

| | | | | | |
|---|---|--|---|--------------------------------|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
ANNE BEITLER | | 2. Date of Death
Month MAY Day 24 Year 1996 | | 3. Time of Death
5:30am |
| | 4a. Facility Name (If not Institution, give street and number)
BRIGHTWOOD NURSING HOME | | 4b. City, Town, or Location of Death
BROOKLANDVILLE | | 4c. County of Death
BALTIMORE |
| Funeral
Director | 5. Social Security Number
218-32-8528 | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)
91 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. |
| | 8. Date of Birth (Month, Day, Year)
DEC. 15, 1904 | | 9. Birthplace (State or Foreign Country)
MARYLAND | | |
| To Be Completed by Funeral Director | Usual Residence of Decedent | | 10a. State
MARYLAND | | 10b. County
N/A |
| | 10c. City, Town or Location
BALTIMORE | | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | |
| | 10e. Street and Number
6611 EBERLE DRIVE | | 10f. Zip Code
21215 | | 10g. Citizen of What Country?
USA |
| | 11. Marital Status
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |
| | 14. Race - American Indian, Black, White, etc.
Specify: WHITE | | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (1-4 or 5+) | | 16. Kind of Business/Industry
PARK CIRCLE MOTOR CO. |
| | 17. Father's Name (First, Middle, Last)
CHARLES LAPIN | | 18. Mother's Name (First, Middle, Maiden Surname)
ESTHER DUKE | | |
| | 19a. Informant's Name/Relationship (Type, Print)
MRS. ESSIE LEVIN (DAUGHTER) | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
7709 GRASTY RD. BALTIMORE, MD 21208 | | |
| | 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
ARLINGTON-CHIZUK AMUNO | | 20c. Location - City or Town, State
BALTIMORE, MD |
| | 21. Signature of Funeral Service Licensee
<i>[Signature]</i> | | 22. Name and Address of Facility
SOL LEVINSON & BROS., INC.
8900 REISTERSTOWN ROAD PIKESVILLE, MD 21208 | | |
| | 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | |
| Physician
/Medical
Examiner | Immediate Cause (Final disease or condition resulting in death) | | a. Status Epilepticus
Due to (or as a consequence of): | | Approximate Interval Between Onset and Death
2 hours |
| | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | b. Parkinsonism
Due to (or as a consequence of): | | 7 years |
| Medical Certification: To Be Completed by Physician/Medical Examiner | c. _____
Due to (or as a consequence of): | | d. _____
Due to (or as a consequence of): | | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Meningitis | | | | |
| | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | |
| | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| | 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | |
| | 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation
<input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined
<input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M |
| | 28c. Injury at Work?
<input type="checkbox"/> Yes <input type="checkbox"/> No | | 28d. Describe how injury occurred | | |
| | 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | |
| | 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | |
| | 29b. Signature and title of certifier
<i>[Signature]</i> | | 29c. License number
D33211 | | 29d. Date signed (Month, Day, Year)
5/24/96 |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
CHRISTINE BELL-IAFFERMAN MD Suite 508 11447 York Rd Lutherville Md 21093 | | | | | |
| State
Registrar | 31. Date filed (Month, Day, Year)
MAY 28 1996 | | 32. Registrar's Signature
<i>[Signature]</i> | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

1. The first part of the report is a general introduction to the subject of the study. It discusses the importance of the problem and the objectives of the research.

2. The second part of the report is a detailed description of the methods used in the study. It includes a discussion of the experimental design, the data collection procedures, and the statistical analysis techniques.

3. The third part of the report is a presentation of the results of the study. It includes a discussion of the findings, the interpretation of the results, and the conclusions drawn from the study.

4. The fourth part of the report is a discussion of the implications of the study. It includes a discussion of the theoretical and practical significance of the findings, and the limitations of the study.

5. The fifth part of the report is a conclusion and a summary of the main findings of the study. It includes a discussion of the overall results and the recommendations for further research.

6. The sixth part of the report is a list of references. It includes a list of the books, articles, and other sources used in the study.

7. The seventh part of the report is an appendix. It includes a list of the tables, figures, and other supplementary material used in the study.

8. The eighth part of the report is a glossary. It includes a list of the terms and abbreviations used in the study.

9. The ninth part of the report is a list of acknowledgments. It includes a list of the people and organizations that provided assistance and support during the study.

10. The tenth part of the report is a list of appendices. It includes a list of the tables, figures, and other supplementary material used in the study.

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last) **ROSHIE PACHINO BUSH**
2. Date of Death Month **MAY** Day **24th** Year **1996**
3. Time of Death **4.30 PM**
4a. Facility Name (If not institution, give street and number) **3001, SOUTH HANOVER STREET, BALTIMORE**
4b. City, Town, or Location of Death **BALTIMORE**
4c. County of Death **N/A**

Funeral
Director

5. Social Security Number **214-36-8789**
6. Sex ☐ M ☒ F
7. Age (In yrs. last birthday) **56** Yrs.
8. Date of Birth (Month, Day, Year) **JUNE 9, 1939**
9. Birthplace (State or Foreign Country) **MD**

Usual Residence of Decedent

10a. State **MD**
10b. County **BALTIMORE**
10c. City, Town or Location **OWINGS MILLS**
10d. Inside City Limits ☒ Yes ☐ No

10e. Street and Number **10904 BARONET ROAD**
10f. Zip Code **21117**
10g. Citizen of What Country? **USA**

11. Marital Status
☐ Never Married ☒ Married
☐ Widowed ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces?
☐ Yes ☒ No
13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
☐ Yes ☒ No Specify:
14. Race - American Indian, Black, White, etc.
Specify: **WHITE**

15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) **4** Collegia (1-4 or 5+) **4**
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
DENTAL HYGIENIST
16b. Kind of Business/Industry
DENTISTRY

17. Father's Name (First, Middle, Last) **HENRY PACHINO**
18. Mother's Name (First, Middle, Maiden Surname) **ANNE GAMERMAN**

19a. Informant's Name/Relationship (Type, Print) **MR. DAVID BUSH (HUSBAND)**
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) **10904 BARONET RD; OWINGS MILLS, MD 21117**

20a. Method of Disposition
☒ Burial ☐ Cremation ☐ Removal from State
☐ Donation ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place) **BETH TFILOH**
20c. Location - City or Town, State **MAY 26, 1996 BALTIMORE, MD**

21. Signature of Funeral Service Licensee
Michael Kruger
22. Name and Address of Facility
SOL LEVINSON & BROS., INC.
8900 REISTERSTOWN ROAD PIKESVILLE, MD 21208

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
a. **ADENOCARCINOMA OF LUNG WITH METASTASES**
Due to (or as a consequence of):
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.
Approximate Interval Between Onset and Death **3 YEARS**

Immediate Cause (Final disease or condition resulting in death)
a. **ADENOCARCINOMA OF LUNG WITH METASTASES**
Due to (or as a consequence of):
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.
Approximate Interval Between Onset and Death **3 YEARS**

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
a.
Due to (or as a consequence of):
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.
Approximate Interval Between Onset and Death **3 YEARS**

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
23b. Did tobacco use contribute to the cause of death?
☐ Yes ☐ No ☒ Probably ☐ Unknown

24a. Was an autopsy performed?
☐ Yes ☒ No
24b. Were autopsy findings available prior to completion of cause of death?
☐ Yes ☐ No

25. Was case referred to medical examiner?
☐ Yes ☒ No
26. Place of Death (Check only one)
Hospital: ☒ Inpatient ☐ ER/Outpatient ☐ DOA
Other: ☐ Nursing Home ☐ Residence ☐ Other (Specify)

27. Manner of Death
☒ Natural ☐ Pending investigation
☐ Accident ☐ Could not be determined
☐ Suicide ☐ Homicide
28a. Date of Injury (Month, Day Year)
28b. Time of Injury **M**
28c. Injury at Work? ☐ Yes ☐ No
28d. Describe how Injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier **RESIDENT**
Usha Srinari INTERNAL MEDICINE
29c. License number **ASS 2441614-25**
29d. Date signed (Month, Day, Year) **MAY 24th 1996**

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) **HARBOR HOSPITAL CENTER, USHA SRIHARI, VEMULAKONDA 3001, SOUTH HANOVER STREET, BALTIMORE, MD, 21225.**

31. Date filed (Month, Day, Year) **MAY 28 1996**
32. Registrar's Signature **John Davidson-Randall**

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23a-1 show any injury or other traumatic event, the Medical Examiner must be notified at 202-691-0020.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
Division of Vital Records
P.O. Box 60760
Baltimore, Maryland 21215-0020

REQUEST FOR CORRECTION/AMENDMENT TO DEATH CERTIFICATE
OF ROSHIE PACHINO BUSH SS # 214-36-8789
DECEDENT

All items on death certificates must be complete and accurate. Please supply the information to be changed in the appropriate space below. Submit it to the Division of Vital Records or Local Health Department in which you registered the original.

SPECIAL INSTRUCTIONS

1. Avoid all abbreviations unless otherwise instructed.
2. Age in years should correspond with date of birth.
3. Do not enter "retired" in response to item 16a "Decedent's Usual Occupation".
4. Check ONE ITEM ONLY for marital status.
5. List complete race, not initials. Example: Black, White, etc. Do not enter "U.S.A." for the race of the decedent.

| | | | | | | | |
|--|--|---|---|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) | | | | 2. DATE OF DEATH (Month, Day, Year) | | 3. TIME OF DEATH | |
| 4. SOCIAL SECURITY NUMBER | | 5. SEX
<input type="checkbox"/> M <input type="checkbox"/> F | 6. AGE (in years and days)
YRS. DAYS | 7. DATE OF BIRTH (Month, Day, Year) | 8. BIRTHPLACE (State or Foreign Country) | | |
| 9a. FACILITY NAME (If not institution, give street and number) | | | 9b. CITY, TOWN OR LOCATION OF DEATH | | 9c. COUNTY OF DEATH | | |
| 10a. STATE | | | | 10b. CITY, TOWN OR LOCATION | | 10c. INSIDE CITY LIMITS
<input type="checkbox"/> YES <input type="checkbox"/> NO | |
| 10d. STREET AND NUMBER | | | | 10e. ZIP CODE | | 10f. CITIZEN OF WHAT COUNTRY | |
| 11. MARITAL STATUS
<input type="checkbox"/> Never married
<input type="checkbox"/> Married
<input type="checkbox"/> Widowed
<input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?
IF YES, GIVE YEAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | | 14. RACE - American Indian, Black, White, etc. (Specify) | |
| 15. DECEDENT'S EDUCATION
(Specify only if kind of education completed) | | | | 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.) | | 16b. KIND OF BUSINESS/INDUSTRY | |
| 17. FATHER'S NAME (First, Middle, Last) | | | | 18. MOTHER'S NAME (First, Middle, Last) | | | |
| 19a. INFORMANT'S NAME (First, Middle, Last) | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) | | | |
| 20a. METHOD OF DISPOSITION
<input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) | | 20c. LOCATION - City or Town, State | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | | | | 22. NAME AND ADDRESS OF FACILITY | | | |

THE STATEMENTS MADE HEREIN ARE MADE UNDER THE PENALTIES OF PERJURY THAT THE MATTERS AND FACTS CONTAINED HEREIN ARE TRUE TO THE BEST OF THE KNOWLEDGE, INFORMATION, AND BELIEF OF THE INDIVIDUAL(S) MAKING THE DECLARATIONS.

Signature of person providing information

IRVIN B. LEVINSON
FUNERAL DIRECTOR

Name, Title
(typed or printed)

5/27/96
Date

IMPORTANT - PLEASE NOTE

DOCUMENTARY EVIDENCE IS REQUIRED FOR CHANGES IN THE DECEDENT'S (1) NAME, (2) RESIDENCE, (3) MARITAL STATUS, (4) DATE OF BIRTH AND AGE, (5) SOCIAL SECURITY NUMBER OR ADDITION OF AN "ALSO KNOWN AS" NAME.

SEE EXAMPLES ON BACK

ITEMS: 1. 17.18. PER F.H.
FILM g-735 5/28/96 t.t

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 15592

Certificate of Death

Reg. No.

| | | | | | | | | | | |
|--|--|---|---|--|---|---|--|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last) KATHRYN MARY BUTTON
KATHRYN BUTTON | | | | 2. Date of Death
Month Day Year
MAY 24 1996 | | 3. Time of Death
5:20 PM | | | |
| | 4a. Facility Name (If not institution, give street and number)
NORTHWEST HOSPITAL CENTER | | | | 4b. City, Town, or Location of Death
RANDALLSTOWN | | 4c. County of Death
BALTIMORE | | | |
| Funeral
Director | 5. Social Security Number
215-78-5864 | | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)
74 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth
(Month, Day, Year)
SEPT. 22, 1921 | 9. Birthplace (State or Foreign Country)
PA | | |
| | Usual Residence of Decedent | | | | | | | | | |
| To Be Completed by Funeral Director | 10a. State
MD | | 10b. County
HOWARD | | 10c. City, Town or Location
COLUMBIA | | | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | |
| | 10e. Street and Number
6336 CEDAR LANE, APT. 251 | | | | 10f. Zip Code
21044 | | 10g. Citizen of What Country?
USA | | | |
| | 11. Marital Status
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc.
Specify: WHITE | | |
| | 15. Decedent's Education
(Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (1-4 or 5+) College | | | | 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)
HOMEMAKER | | | 16b. Kind of Business/Industry
OWN HOME | | |
| | 17. Father's Name (First, Middle, Last)
HOWARD NEIBELL NIEBELL | | | | 18. Mother's Name (First, Middle, Maiden Surname)
CAROLYN RAUSCHMEIER RAUSCHMEIER | | | | | |
| | 19a. Informant's Name/Relationship (Type, Print)
MRS. KAREN BERLIN (DAUGHTER) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
4510 PROSPECT AVE; GLYNDON, MD 21071 | | | | | |
| | 20a. Method of Disposition
<input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
HILLTOP SERV. CORP | | Date
MAY 25, 1996 | | 20c. Location - City or Town, State
TOWSON, MD | | | |
| | 21. Signature of Funeral Service Licensee
 | | | | 22. Name and Address of Facility
SOL LEVINSON & BROS., INC.
8900 REISTERSTOWN ROAD PIKESVILLE, MD 21208 | | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. PNEUMONIA
Due to (or as a consequence of):

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of): | | | | | | | | Approximate Interval Between Onset and Death
3 WEEKS | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
DIABETES
HYPERTENSION
DEMENTIA | | | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | | |
| 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No | | | | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input type="checkbox"/> No | | 28d. Describe how injury occurred | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier
K.S. RAO, M.D. | | | | | | | | |
| 29c. License number
D 43462 | | 29d. Date signed (Month, Day, Year)
MAY 24 1996 | | | | | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
K.S. RAO, M.D. NORTHWEST HOSPITAL CENTER, RANDALLSTOWN MD | | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
MAY 28 1996 | | 32. Registrar's Signature
 | | | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Certificate of Death

Reg. No.

| | | | | | | | | | | |
|---|--|---|---|--|--|--|---|---|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
BERNARD BOYD | | | | 2. Date of Death
Month Day Year
MAY 22, 1996 | | 3. Time of Death
7:30 AM | | | |
| | 4a. Facility Name (If not institution, give street and number)
ST. JOSEPH MEDICAL CENTER | | | | 4b. City, Town, or Location of Death
TOWSON | | 4c. County of Death
BALTIMORE | | | |
| Funeral
Director | 5. Social Security Number
215-16-5408 | | 8. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (in yrs. last birthday)
73 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 6. Date of Birth (Month, Day, Year)
Sept. 1, 1922 | 9. Birthplace (State or Foreign Country)
Maryland | | |
| | Usual Residence of Decedent
10a. State Maryland 10b. County N/A 10c. City, Town or Location Baltimore 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | 10f. Zip Code
21216 | | 10g. Citizen of What Country?
USA | | | |
| To Be Completed by Funeral Director | 11. Marital Status
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: Negro | | | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (1-4or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Electrician | | 16b. Kind of Business/Industry
Westinghouse | | | | | |
| | 17. Father's Name (First, Middle, Last)
William Boyd | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Hattie Hackett | | | | | |
| | 19a. Informant's Name Relationship (Type, Print)
Mrs. Ruth Boyd | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
3039 Presstman St. Balto. Md. 21216 | | | | | |
| | 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery)
GARRISON FOREST 5/29/96 | | 20c. Location - City or Town, State
OWINGS HILLS Balto. Md. | | | | | |
| | 21. Signature of Funeral Service Licensee
Joseph L. Russ | | | | 22. Name and Address of Facility
Joseph L. Russ Funeral Home 2222 W. North Ave. Balto. Md. 21216 | | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

MULTIPLE MYELOMA
Due to (or as a consequence of):

ACUTE RENAL FAILURE

HYPERCALCEMIA

Due to (or as a consequence of):

Due to (or as a consequence of):

Due to (or as a consequence of): | | | | | | | | Approximate Interval Between Onset and Death
1 WEEK | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

ACUTE RENAL FAILURE

HYPERCALCEMIA | | | | | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | |
| | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| | 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input type="checkbox"/> No | | 28d. Describe how Injury occurred | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier
R. Huslig | | 29c. License number
D360814 | | 29d. Date signed (Month, Day, Year)
5/22/96 | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
RICHARD L. HUSLIG, M.D., 7505 OSLER DR., TOWSON, MD. 21204 | | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
MAY 28 1996 | | 32. Registrar's Signature
John Anderson-Rodell | | | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

5+1

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 15594

Certificate of Death

Reg. No.

| | | | | | | | | |
|--|---|---|---|--|--|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Mary Anthony Bland | | | | 2. Date of Death
Month May Day 21 Year 1996 | | 3. Time of Death
14:52 hrs. | |
| | 4a. Facility Name (If not institution, give street and number)
2203 Mt. Holly St. | | | | 4b. City, Town, or Location of Death
Baltimore | | 4c. County of Death
N/A | |
| Funeral
Director | 5. Social Security Number
214-14-0077A | | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday)
72 Yrs. | | 8. Date of Birth
Month Aug. Day 24 Year 1923 | |
| | 9. Birthplace (State or Foreign Country)
North Carolina | | 10a. State
Maryland | | 10b. County
N/A | | 10c. City, Town or Location
Baltimore | |
| To Be Completed by Funeral Director | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 10e. Street and Number
7420 Remoor Rd. | | 10f. Zip Code
21207 | | 10g. Citizen of What Country?
USA | |
| | 11. Marital Status
<input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: Negro | |
| To Be Completed by Physician/Medical Examiner | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 6 College (1-4 or 5+) 0 | | 18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Tavern Owner | | 18b. Kind of Business/Industry
Self-employed | | | |
| | 17. Father's Name (First, Middle, Last)
Bennie Bland | | 18. Mother's Name (First, Middle, Maiden Surname)
Mary Reaves | | | | | |
| Physician
/Medical
Examiner | 19a. Informant's Name/Relationship (Type, Print)
Mrs. Addie Bland | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
7420 Remoor Rd. Balto. Md. 21207 | | | | | |
| | 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Arbutus | | 20c. Location - City or Town, State
Balto. Co. Md. | | 20d. Date
5/24/96 | |
| Physician
/Medical
Examiner | 21. Signature of Funeral Service Licensee
Joseph L. Russ | | 22. Name and Address of Facility
Joseph L. Russ Funeral Home
2222 W. North Ave. Balto. Md. 21216 | | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. Small cell carcinoma of left lung
Due to (or as a consequence of):
with liver metastasis

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of): | | Approximate Interval Between Onset and Death
5 months | | | | | |
| Division of Vital Records, P.O. Box 68760,
Baltimore, Maryland 21215-0020 | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Severe dilated cardiomyopathy
Hypertensive cardiovascular disease
Chronic obstructive lung disease, strokes | | 23b. Did tobacco use contribute to the cause of death?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | |
| | 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death?
NA
<input type="checkbox"/> Yes <input type="checkbox"/> No | |
| State Registrar | 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day Year)
May 21 1996 | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| | 28d. Describe how injury occurred
--- | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
--- | | 28f. Location (Street and Number or Rural Route Number, City or Town, State)
--- | | | |
| State Registrar | 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier
Komal K. Dang MD | | 29c. License number
D18362 | | 29d. Date signed (Month, Day, Year)
May/22/1996 | |
| | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Komal K. Dang MD, 3455, Wilkens Ave, Balto., Md 21229. | | | | | | | |
| 31. Date filed (Month, Day, Year)
MAY 28 1996 | | 32. Registrar's Signature
John Davidson-Randall | | | | | | |

Certificate of Death

Reg. No.

| | | | | | | | | |
|---|--|---|--|--|--|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Clarence Junior Ball | | | | 2. Date of Death
Month 05 Day 23 Year 96 | | 3. Time of Death
1313 | |
| | 4a. Facility Name (If not institution, give street and number)
17225 Troyer Road | | | | 4b. City, Town, or Location of Death
Monkton | | 4c. County of Death
Baltimore | |
| Funeral
Director | 5. Social Security Number
220-42-7132 | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)
51 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth (Month, Day, Year)
03/14/96 | 9. Birthplace (State or Foreign Country)
Baltimore, MD |
| | Usual Residence of Decedent | | | | | | | |
| 10a. State
MD | | 10b. County
Baltimore | | 10c. City, Town or Location
Monkton | | | 10d. Inside City Limits
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | |
| 10e. Street and Number
17225 Troyer Road | | | | 10f. Zip Code
21111 | | 10g. Citizen of What Country?
USA | | |
| 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc.
Specify: Black | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 10 College (1-4 or 5+) N/A | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Driver | | | 16b. Kind of Business/Industry
Trucking | |
| 17. Father's Name (First, Middle, Last)
George Walter Ball | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Lillian Louisa Trafton | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
Lillie Mae Cromwell | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
17747 Troyer Rd. Whitehall, Maryland 21161 | | | | |
| 20a. Method of Disposition
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of other place)
STEVENS AVE
Cough United Methodist
Church Cemetery | | 20c. Location - City or Town, State
Sparks, MD | | |
| 21. Signature of Funeral Service Licensee
<i>[Signature]</i>
Lemmon | | | | 22. Name and Address of Facility
Lemmon Funeral Home of Dulaney Valley Inc.
10 W. Padonia Road Timonium, Maryland 21093 | | | | |
| 23a. Part I: Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. Chronic liver failure
Due to (or as a consequence of):
b. Chronic alcoholism
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last | | | | | | | | Approximate Interval Between Onset and Death |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death?
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | |
| | | | | | | 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | |
| | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | |
| 25. Was case referred to medical examiner?
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred |
| | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. Certifier (Check only one)
1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | |
| 29b. Signature and title of certifier
J. Crossan O'Leary, M.D. | | | | 29c. License number
DO 7632 | | 29d. Date signed (Month, Day, Year)
MAY 25, 1996 | | |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)
J. CROSSAN O'LEARY 2112 DUNDALK AVE BALTO MD 21222 | | | | | | | | |
| 31. Date filed (Month, Day, Year)
MAY 28 1996 | | 32. Registrar's Signature
<i>[Signature]</i> | | | | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

96 15596

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
<i>Lorenzo Bowersox</i> | | | | 2. DATE OF DEATH
MONTH <i>May</i> DAY <i>23</i> YEAR <i>1996</i> | | 3. TIME OF DEATH
<i>2:35 AM</i> | |
| 4. SOCIAL SECURITY NUMBER
<i>078-03-8080</i> | | 5. SEX
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
<i>90</i> YRS. | | 7. DATE OF BIRTH
(Month, Day, Year)
<i>Nov. 28, 1905</i> | |
| 8. BIRTHPLACE (State or Foreign Country)
<i>NORGE, OK</i> | | | | 9. FACILITY NAME (If not institution, give street and number)
<i>LORIEEN NURSING HOME</i> | | 10. CITY, TOWN OR LOCATION OF DEATH
<i>COLUMBIA</i> | |
| 11. COUNTY OF DEATH
<i>HOWARD</i> | | | | 12. RESIDENCE OF DECEDENT
10a. STATE <i>MD.</i> 10b. COUNTY <i>HOWARD</i> 10c. CITY, TOWN OR LOCATION <i>ELICOTT CITY</i> | | 13. INSIDE CITY LIMITS?
<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | |
| 14. STREET AND NUMBER
<i>2344 CALVIN CIRCLE</i> | | | | 15. ZIP CODE
<i>21042</i> | | 16. CITIZEN OF WHAT COUNTRY?
<i>U.S.A.</i> | |
| 17. MARITAL STATUS
1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 18. WAS DECEDENT EVER IN U.S. ARMED FORCES?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 19. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 20. RACE — American Indian, Black, White, etc.
Specify:
<i>WHITE</i> | |
| 21. DECEDENT'S EDUCATION
(Specify only highest grade completed)
Elementary/Secondary (0-12) <i>12</i> College (1-4 or 5+) <i>2</i> | | 22. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.)
<i>INSURANCE REP.</i> | | 23. KIND OF BUSINESS/INDUSTRY
<i>INSURANCE</i> | | | |
| 24. FATHER'S NAME (First, Middle, Last)
<i>DORWIN D. BOWERSOX</i> | | | | 25. MOTHER'S NAME (First, Middle, Maiden Surname)
<i>MAY ROYLE</i> | | | |
| 26. INFORMANT'S NAME (Type/Print)
<i>DAVID BOWERSOX</i> | | | | 27. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
<i>2344 CALVIN CIRCLE ELICOTT CITY, MD. 21042</i> | | | |
| 28. METHOD OF DISPOSITION
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 29. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory, or other place)
<i>WEST SOMERSET CEM. MAY 28, 1996 TOWN OF SOMERSET N.Y.</i> | | 30. LOCATION — City or Town, State
<i>N.Y.</i> | | | |
| 31. SIGNATURE OF FUNERAL SERVICE LICENSEE
<i>Thomas J. Skarda Jr.</i> | | | | 32. NAME AND ADDRESS OF FACILITY
<i>SKARDA F.H. 2829 HUDSON ST. BALTO., MD. 21224</i> | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | | a. <i>aspiration pneumonia</i> | | | | Approximate Interval Between Onset and Death
<i>acute</i> | |
| | | b. <i>Swallowing disorder</i> | | | | " | |
| | | c. <i>dementia - NOS</i> | | | | " | |
| | | d. | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
<i>N/A</i> | | | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DCA
OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation
2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide
3 <input type="checkbox"/> Homicide 7 <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
<i>M</i> | | 28c. INJURY AT WORK?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| | | 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |
| 29. CERTIFIER (Check only one)
1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
<i>R. Kolodrubetz</i> | | | | 29c. LICENSE NUMBER
<i>D31575</i> | | 29d. DATE SIGNED (Month, Day, Year)
<i>May 24, 1996</i> | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
<i>R Kolodrubetz 801 OLD Annapolis Rd Ellicott City, MD 21042</i> | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
<i>MAY 28 1996</i> | | 32. REGISTRAR'S SIGNATURE
<i>J. Davidson-Randall</i> | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 15597

Certificate of Death

Reg. No.

| | | | | | | | | |
|---|--|--|--|---|---|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
<u>Lorman A. Bell</u> | | | | 2. Date of Death
Month <u>May</u> Day <u>23</u> Year <u>1996</u> | | 3. Time of Death
<u>1:20 AM</u> | |
| | 4a. Facility Name (If not institution, give street and number)
<u>LIBERTY MEDICAL CENTER</u> | | | | 4b. City, Town, or Location of Death
<u>BALTIMORE CITY</u> | | 4c. County of Death
<u>N/A</u> | |
| Funeral
Director | 5. Social Security Number
<u>215-03-7914</u> | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday)
<u>94</u> Yrs. | | 8. Date of Birth (Month, Day, Year)
<u>May 12 1902</u> | |
| | 9. Birthplace (State or Foreign Country)
<u>MARYLAND</u> | | 10. Usual Residence of Decedent
10a. State <u>MARYLAND</u> 10b. County <u>N/A</u> 10c. City, Town or Location <u>BALTIMORE CITY</u> 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 11. Marital Status
<input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever In U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | |
| To Be Completed by Funeral Director | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | | 14. Race - American Indian, Black, White, etc.
Specify: <u>BLACK</u> | | | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) <u>5th grade</u> College (1-4or 5+) <u>Retired</u> | | | | 16. Kind of Business/Industry
<u>Laborer</u> | | | |
| | 17. Father's Name (First, Middle, Last)
<u>Amos Bell</u> | | | | 18. Mother's Name (First, Middle, Maiden Surname)
<u>Saphronia Bell</u> | | | |
| | 19. Informant's Name/Relationship (Type, Print)
<u>Anna Nelson</u> | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
<u>2745 Riggs Avenue, Baltimore, Maryland 21216</u> | | | |
| Physician
/Medical
Examiner | 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
<u>Mt. Zion Cemetery</u> | | Date
<u>5-28-96</u> | | 20c. Location - City or Town, State
<u>BALTIMORE, MARYLAND</u> | |
| | 21. Signature of Funeral Service Licensee
<u>Hani P. Close</u> | | | | 22. Name and Address of Facility
<u>WILLIAM C. BROWN COMMUNITY F/H</u>
<u>1206 W. NORTH AVENUE</u> | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
Immediate Cause (Final disease or condition resulting in death)
e. <u>Chronic Obstructive Pulmonary Disease</u>
Due to (or as a consequence of):
b. <u>Cardiac Arrhythmias</u>
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last | | | | | | | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
<u>Hypertension</u> | | | | | | | |
| Medical Certification: To Be Completed by Physician/Medical Examiner | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown | | | | 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | |
| | 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | 25. Was case referred to medical examiner?
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | |
| | 26. Place of Death (Check only one)
Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | | |
| | 28a. Date of Injury (Month, Day, Year)
<u>May 12 1902</u> | | | | 28b. Time of Injury
<u>M</u> | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| 28d. Describe how Injury occurred
<u>2600 Liberty Heights Ave 21215</u> | | | | | | | | |
| 29a. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | |
| 29b. Signature and title of certifier
<u>George E. Wicks III M.D.</u> | | | | 29c. License number
<u>D41365</u> | | 29d. Date signed (Month, Day, Year)
<u>May 23, 1996</u> | | |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)
<u>George E. Wicks III</u> <u>2600 Liberty Heights Ave 21215</u> | | | | | | | | |
| 31. Date filed (Month, Day, Year)
<u>MAY 28 1996</u> | | | | 32. Registrar's Signature
<u>John A. ...</u> | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 15598

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

ALBERT BARNES JR

2. Date of Death

Month Day Year
MAY 21 1996

3. Time of Death

3.15 PM

4a. Facility Name (If not institution, give street and number)

SAINT AGNES HOSPITAL

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

N/A

Funeral
Director

5. Social Security Number

245-16-2899

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

72 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

6. Date of Birth

(Month, Day, Year)
MAR 11, 1924

9. Birthplace (State or Foreign Country)

NORTH CAROLINA

Usual Residence of Decedent

10a. State

MD.

10b. County

N/A

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

3410 JOANN DRIVE

10f. Zip Code

21244

10g. Citizen of What Country?

USA

11. Marital Status

☐ Never Married ☒ Married
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces? ☒ Yes ☐ No

If Yes, Give Year or Dates: 7/15/43

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

12th

3 yrs

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

DIR. OF PLANT MANAGEMENT

16b. Kind of Business/Industry

U.S. POSTAL SERV.

17. Father's Name (First, Middle, Last)

CHALMERS AARON BARNES

18. Mother's Name (First, Middle, Maiden Surname)

OPHELIA WILLOUGHBY

19a. Informant's Name/Relationship (Type, Print)

MARIE B. BARNES (WIFE)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3410 JOANN DRIVE BALTIMORE, MD. 21244

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State
☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

GARRISON FOREST

Date

5/24/96

20c. Location - City or Town, State

OWINGS MILLS, MD.

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

CAPLE FUNERAL SERVICE
5502 WINNER AVENUE BALTO, MD. 21215

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. Sepsis
Due to (or as a consequence of):

Approximate Interval Between Onset and Death

2 days

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Pneumonia
Due to (or as a consequence of):

10 days

c. Deep Venous Thrombosis
Due to (or as a consequence of):

10 days

d. CHF
Due to (or as a consequence of):

more than 1 yr.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

HTN / CRF / IDDM

COPD, elevated LFT.

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☒ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☒ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

26. Place of Death (Check only one)

Hospital:

☒ Inpatient☐ ER/Outpatient☐ DOA

Other:

☐ Nursing Home☐ Residence☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending investigation
☐ Accident ☐ Could not be determined
☐ Suicide ☐ Homicide

28a. Date of injury (Month, Day, Year)

28b. Time of injury

28c. Injury at Work?

☐ Yes ☒ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

PO 9139

29d. Date signed (Month, Day, Year)

5/21/96

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Ewa RACMOCKA, 900 CATON Ave, BALTO, MD

31. Date filed (Month, Day, Year)

MAY 28 1996

32. Registrar's Signature

State
Registrar

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 15599

| | | | | | | | | | |
|---|--|--|---|--|--|--|---|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
HERMAN BRANCH | | | | 2. Date of Death
Month MAY Day 25 Year 1996 | | 3. Time of Death
10:22 A | | |
| | 4a. Facility Name (If not Institution, give street and number)
BAYVIEW MEDICAL CENTER | | | | 4b. City, Town, or Location of Death
BALTIMORE | | 4c. County of Death
N/A | | |
| Funeral
Director | 5. Social Security Number
230-16-3157 | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday)
71 Yrs. | | 8. Date of Birth (Month, Day, Year)
OCT 22, 1924 | | |
| | 9. Birthplace (State or Foreign Country)
VIRGINIA | | 10a. State
MD. | | 10b. County
N/A | | 10c. City, Town or Location
BALTIMORE | | |
| To Be Completed by Funeral Director | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 10e. Street and Number
3236 TIOGA PARKWAY | | 10f. Zip Code
21215 | | 10g. Citizen of What Country?
USA | | |
| | 11. Marital Status
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
If Yes, Give Year or Dates: 8-14-50 to 8-9-52 | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: BLACK | | |
| To Be Completed by Physician/Medical Examiner | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12TH College (1-4or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
BRICKLAYER | | 16b. Kind of Business/Industry
STEEL | | | | |
| | 17. Father's Name (First, Middle, Last)
FLETCHER BRANCH | | 18. Mother's Name (First, Middle, Maiden Surname)
LIZZIE BRAME | | 19a. Intendant's Name/Relationship (Type, Print)
LORENA L. BRANCH (WIFE) | | | | |
| To Be Completed by Physician/Medical Examiner | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
5906 LOCH RAVEN BLVD. BALTIMORE, MD 21239 | | 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
MT. ZION BAPT CEM | | 20c. Location - City or Town, State
5/31/96 DOWNINGS, VA. | | |
| | 21. Signature of Funeral Service Licensee
 | | 22. Name and Address of Facility
CAPLE FUNERAL SERVICE
5502 WINNER AVE BALTIMORE, MD. 21215 | | | | | | |
| To Be Completed by Physician/Medical Examiner | 23. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

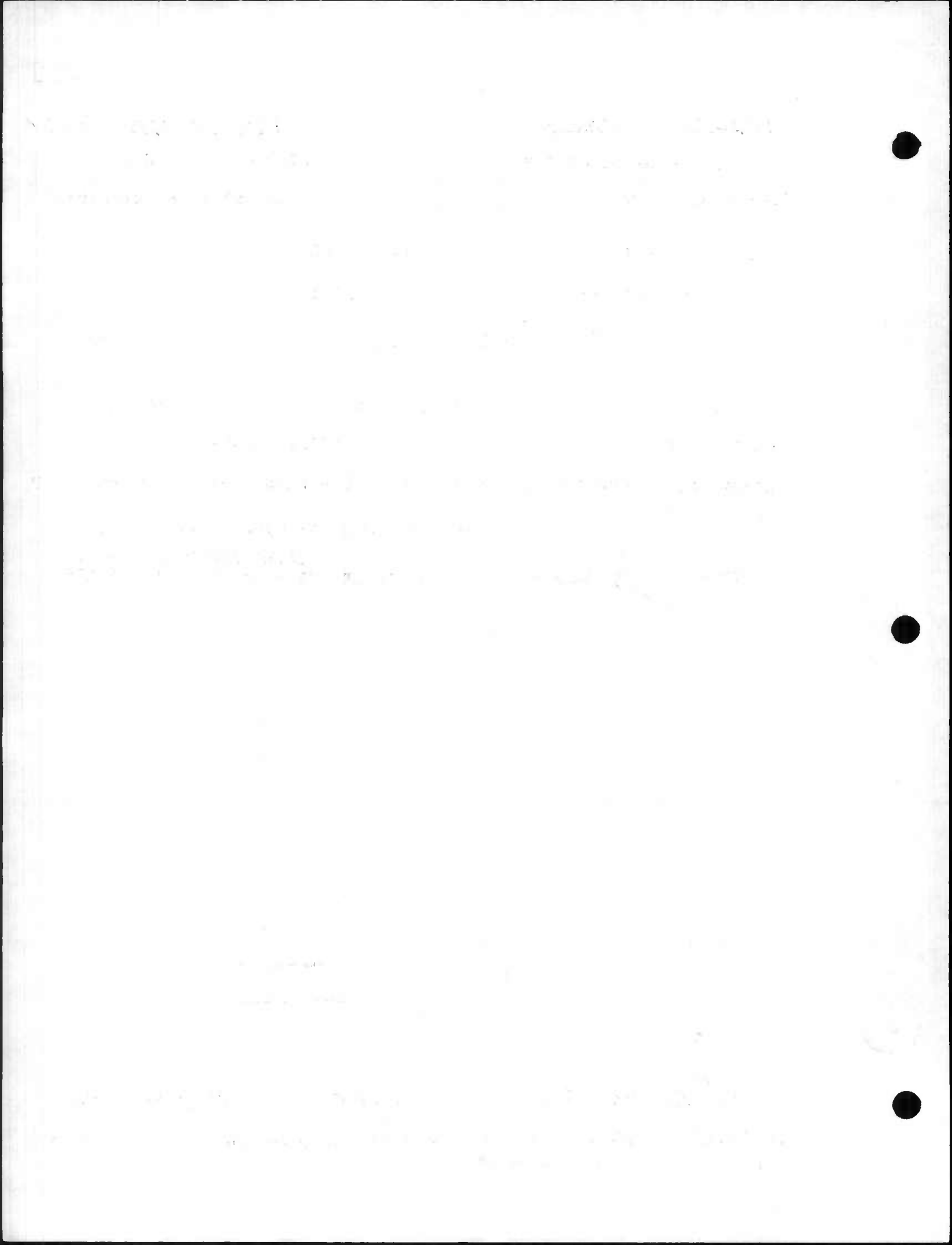
Immediate Cause (Final disease or condition resulting in death)
a. END STAGE CARDIOMYOPATHY
Due to (or as a consequence of):
b. HYPERTENSION
Due to (or as a consequence of):
c. END STAGE RENAL DISEASE
Due to (or as a consequence of):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last | | | | | | | Approximate Interval Between Onset and Death
2 YEARS
8 YEARS
10 YEARS | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
STROKE | | | | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | |
| To Be Completed by Physician/Medical Examiner | 24a. Was an autopsy performed?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | |
| | 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | |
| To Be Completed by Physician/Medical Examiner | 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| | 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28d. Describe how Injury occurred

28e. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | |
| To Be Completed by Physician/Medical Examiner | 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | 29b. Signature and title of certifier
 | |
| | 29c. License number
L9768 | | 29d. Date signed (Month, Day, Year)
MAY 25, 1996 | | | | | | |
| To Be Completed by Physician/Medical Examiner | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
S. NAJJAR, Tower 110 600 N. Wolfe St. Johns Hopkins Hosp Balto, Md 21231 | | | | | | | 31. Date signed (Month, Day, Year)
MAY 28 1996 | |
| | 32. Registrar's Signature
 | | | | | | | 33. Registrar's Title
5+1 | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 15600

Certificate of Death

Reg. No.

| | | | | | | | | |
|--|--|---------------------------|---|--|--|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
WALTER BARNES | | | | 2. Date of Death
Month Day Year
MAY 20, 1996 | | 3. Time of Death
1315 PM | |
| | 4a. Facility Name (If not institution, give street and number)
227 SOUTH BROADWAY STREET ROOM#30 | | | | 4b. City, Town, or Location of Death
BALTIMORE | | 4c. County of Death
N/A | |
| Funeral
Director | 5. Social Security Number
257-32-4741 | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)
68 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth (Month, Day, Year)
JAN 01, 1928 | 9. Birthplace (State or Foreign Country)
Georgia |
| | Usual Residence of Decedent | | | | | | | |
| To Be Completed by Funeral Director | 10a. State
MD | 10b. County
N/A | 10c. City, Town or Location
Baltimore | | | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | |
| | 10e. Street and Number
227 South Broadway | | | 10f. Zip Code
21231 | | 10g. Citizen of What Country?
USA | | |
| | 11. Marital Status
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: Black | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 5th College (1-4or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Laborer | | | 16b. Kind of Business/Industry
Demolition | | |
| | 17. Father's Name (First, Middle, Last)
Albert Barnes | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Unknown | | | |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print)
Linda Barnes (wife) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
206 South Balboa Ct Balto, Md 21231 | | | |
| | 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
MT. ZION CEM | | Date
5/25/96 | | 20c. Location - City or Town, State
Lansdowne, Md | |
| | 21. Signature of Funeral Service Licensee
Dan B. Cogh | | | | 22. Name and Address of Facility
CAPLE FUNERAL SERVICE
5502 WINNER AVE. BALTO, MD 21215 | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. atherosclerotic cardiovascular disease
Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | |
| Medical Certification: To Be Completed by Physician/Medical Examiner | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | | | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | |
| | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | |
| | 25. Was case referred to medical examiner?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| | 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation
<input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined
<input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input type="checkbox"/> No | |
| | 28d. Describe how injury occurred | | | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | |
| 29a. Certifier (Check only one)
<input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | |
| 29b. Signature and title of certifier
[Signature] | | | | 29c. License number
O.C.M.E. | | 29d. Date signed (Month, Day, Year)
MAY 21, 1996 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Amixen 111 Penn Street, Baltimore, Maryland 21201 | | | | | | | | |
| 31. Date filed (Month, Day, Year)
MAY 28 1996 | | | | 32. Registrar's Signature
[Signature] | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

1+1

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 15601

Certificate of Death

Reg. No.

| | | | | | | | | |
|---|---|--|---|--|---|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
RUTH WALES BATTAGLIA | | | | 2. Date of Death
Month MAY Day 23 Year 1996 | | 3. Time of Death
1240 pm | |
| | 4e. Facility Name (If not institution, give street and number)
St. Agnes Hospital | | | | 4b. City, Town, or Location of Death
Baltimore | | 4c. County of Death
n/a | |
| Funeral
Director | 5. Social Security Number
488-22-8650 | | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday)
75 Yrs. | | 8. Date of Birth (Month, Day, Year)
11/10/20 | |
| | 9. Birthplace (State or Foreign Country)
Mo. | | 10a. State
MD | | 10b. County
Baltimore | | 10c. City, Town or Location
Catonsville | |
| Usual Residence of Decedent | | | | | | | | |
| 10e. Street and Number
1101 Outlet Mills Court | | | 10f. Zip Code
21228 | | | 10g. Citizen of What Country?
USA | | |
| 11. Marital Status
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | | 12. Was Decedent Ever in U.S. Armed Forces?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
If Yes, Give Year or Dates: | | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | |
| 14. Race - American Indian, Black, White, etc.
Specify: White | | | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12th
College (1-4 or 5+) College | | | 16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
WAVE | | |
| 17. Father's Name (First, Middle, Last)
Elmer Wales | | | 18. Mother's Name (First, Middle, Maiden Surname)
Edith Meyer | | | 19. Informant's Name/Relationship (Type, Print) Husband
Frank J. Battaglia | | |
| 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Crestlawn Cemetery | | | 20c. Location - City or Town, State
Marriottsville, Md. | | |
| 21. Signature of Funeral Service Licensee
 | | | 22. Name and Address of Facility
Joseph N. Zannino Jr. F. Home
263 S. Conkling St. Baltimore, Md. 21224 | | | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

a. INTRACEREBRAL HEMORRHAGE.
Due to (or as a consequence of):

b.
Due to (or as a consequence of):

c.
Due to (or as a consequence of):

d.
Due to (or as a consequence of): | | |
| 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | 26. Place of Death (Check only one)
Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | |
| 28a. Date of Injury (Month, Day Year) | | | 28b. Time of Injury
M | | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | |
| 29b. Signature and title of certifier

MD | | | 29c. License number
P09884 | | | 29d. Date signed (Month, Day, Year)
MAY 23 1996 | | |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)
DR. K. VENKATARAM ST. AGNES HOSPITAL 906 CATON AVE. BALTIMORE. | | | | | | | | |
| 31. Date filed (Month, Day, Year)
MAY 28 1996 | | | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

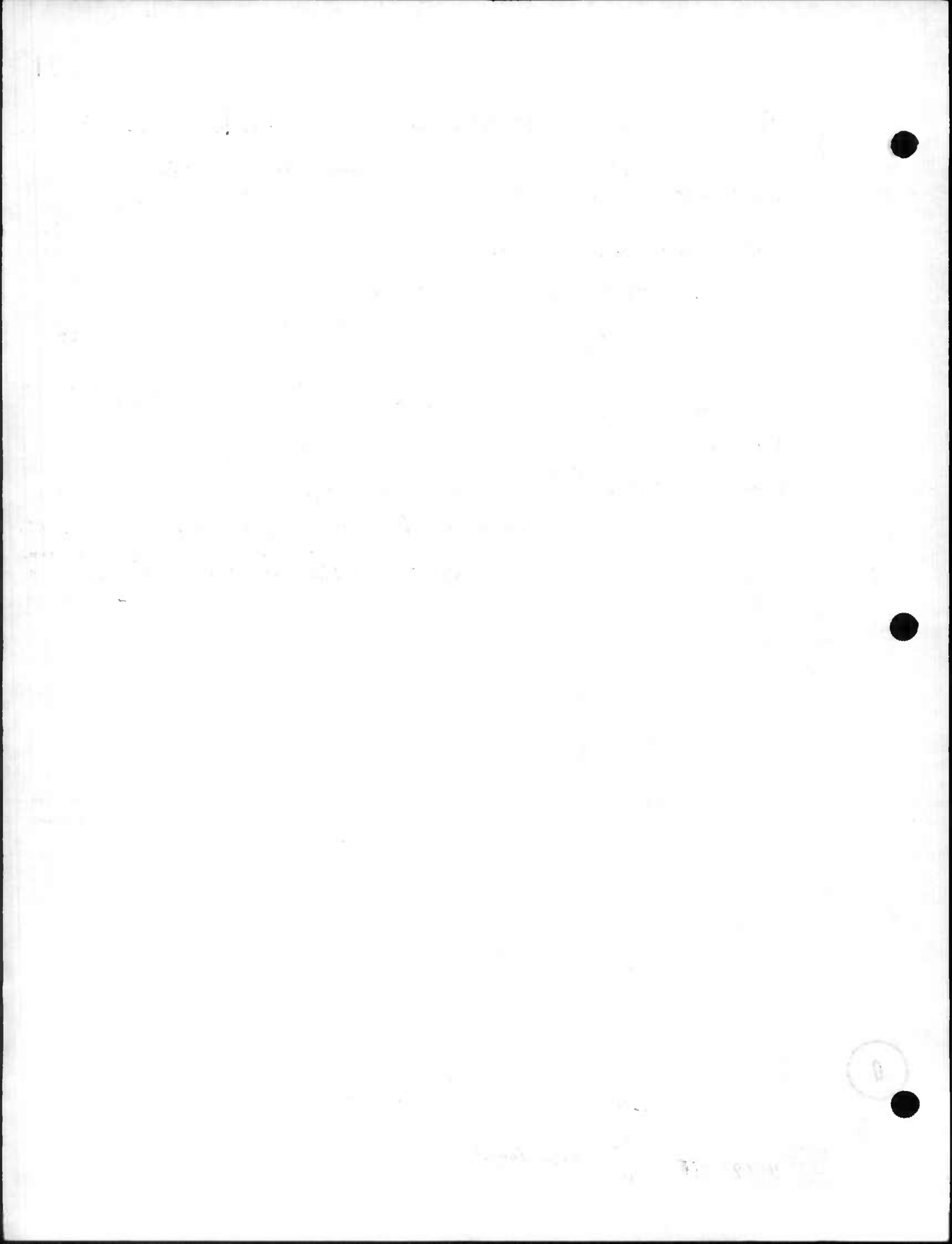
Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 15602

Certificate of Death

Reg. No.

| | | | | | | | | |
|---|---|--|--|--|---|--|---|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
JOSEPH BUCCI | | | | 2. Date of Death
Month Day Year
MAY 26, 1996 | | 3. Time of Death
01:35 P | |
| | 4a. Facility Name (If not institution, give street and number)
THE JOHNS HOPKINS HOSPITAL | | | | 4b. City, Town, or Location of Death
BALTIMORE CITY | | 4c. County of Death
N/A | |
| Funeral
Director | 5. Social Security Number
216-32-9240 | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday)
59 Yrs. | | 8. Date of Birth (Month, Day, Year)
Jan. 10, 1937 | |
| | 9. Birthplace (State or Foreign Country)
Maryland | | 10a. State
Maryland | | 10b. County
Baltimore | | 10c. City, Town or Location
Baltimore | |
| To Be Completed by Funeral Director | 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 10e. Street and Number
2013 Codd Avenue | | 10f. Zip Code
21222 | |
| | 10g. Citizen of What Country?
U.S.A. | | | | 11. Marital Status
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | |
| To Be Completed by Physician/Medical Examiner | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | | 14. Race - American Indian, Black, White, etc.
Specify: White | | 15. Decedent's Education (Specify only highest grade completed)
10th | |
| | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Longshoreman | | | | 16b. Kind of Business/Industry
Transportation | | 17. Father's Name (First, Middle, Last)
Dominic Francis Bucci, Sr. | |
| To Be Completed by Physician/Medical Examiner | 18. Mother's Name (First, Middle, Maiden Surname)
Monica Irene Gasiorowski | | | | 19a. Informant's Name/Relationship (Type, Print)
Dominic F. Bucci, Jr., brother | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
2013 Codd Avenue, Baltimore, Md. 21222 | |
| | 20a. Method of Disposition
<input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input checked="" type="checkbox"/> Other (Specify) Entombment | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Cedar Hill Cemetery | | 20c. Location - City or Town, State
5-30-96 Baltimore, Md. | |
| To Be Completed by Physician/Medical Examiner | 21. Signature of Funeral Service Licensee
 | | | | 22. Name and Address of Facility
Matthews Funeral Home
3021 Eastern Ave., Baltimore, Md. 21224 | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. ACUTE RESPIRATORY DISTRESS SYNDROME
Due to (or as a consequence of):

b. SMALL CELL LUNG CANCER
Due to (or as a consequence of):

c. _____
Due to (or as a consequence of):

d. _____

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | Approximate Interval Between Onset and Death

2 DAYS

1 WEEK | | | |
| To Be Completed by Physician/Medical Examiner | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
CORONARY ARTERY DISEASE | | | | 23b. Did tobacco use contribute to the cause of death?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | |
| | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No | | | |
| To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one)
Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | |
| | 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | | | 28a. Date of Injury (Month, Day Year)
M | | | |
| To Be Completed by Physician/Medical Examiner | 28b. Time of Injury
M | | | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input type="checkbox"/> No | | | |
| | 28d. Describe how Injury occurred | | | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | |
| To Be Completed by Physician/Medical Examiner | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | |
| | 29b. Signature and title of certifier
 | | | | 29c. License number
D47390 | | | |
| To Be Completed by Physician/Medical Examiner | 29d. Date signed (Month, Day, Year)
MAY 26, 1996 | | | | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
IVAN BOBBELLO MD JOHNS HOPKINS ONCOLOGY CENTER | | | |
| | 31. Date filed (Month, Day, Year)
MAY 28 1996 | | | | 32. Registrar's Signature
 | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 15603

Certificate of Death

Reg. No.

| | | | | | | | | |
|---|--|--|--|--|--|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Edward Louis Buchheister | | | | 2. Date of Death
Month Day Year
May 24, 1996 | | 3. Time of Death
3:30 AM | |
| | 4e. Facility Name (If not institution, give street and number)
4328 Shamrock Avenue | | | | 4b. City, Town, or Location of Death
Baltimore | | 4c. County of Death
N/A | |
| Funeral
Director | 5. Social Security Number
213-07-1038 | | 6. Sex
1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 7. Age (In yrs. last birthday)
89 Yrs. | | 8. Date of Birth (Month, Day, Year)
2/11/1907 | |
| | 9. Birthplace (State or Foreign Country)
Maryland | | 10a. State
MD | | 10b. County
N/A | | 10c. City, Town or Location
Baltimore | |
| Usual Residence of Decedent | | | | | | | | |
| 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | | |
| 10e. Street and Number
4328 Shamrock Avenue | | | | | | | | |
| 10f. Zip Code
21206 | | | | | | | | |
| 10g. Citizen of What Country?
U.S.A. | | | | | | | | |
| 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | | | | | | | |
| 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | | | | | | | |
| 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | | | | | | |
| 14. Race - American Indian, Black, White, etc.
Specify: White | | | | | | | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) College (1-4 or 5+)
12 | | | | | | | | |
| 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Electric Welder | | | | | | | | |
| 16b. Kind of Business/Industry
Steel Mill | | | | | | | | |
| 17. Father's Name (First, Middle, Last)
Jacob Henry Buchheister | | | | | | | | |
| 18. Mother's Name (First, Middle, Maiden Surname)
Anna Simon | | | | | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
Theresa Buchheister | | | | | | | | |
| 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
4328 Shamrock Avenue Baltimore, Maryland 21206 | | | | | | | | |
| 20a. Method of Disposition
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | | | | | |
| 20b. Place of Disposition (Name of cemetery, crematory or other place)
Gardens of Faith Cemetery | | | | | | | | |
| 20c. Date
5/28/96 | | | | | | | | |
| 20d. Location - City or Town, State
Baltimore, Maryland | | | | | | | | |
| 21. Signature of Funeral Service Licensee
<i>John J. Dippel</i> | | | | | | | | |
| 22. Name and Address of Facility
The Dippel Funeral Home Inc.
7110 Belair Road Baltimore, Maryland 21206 | | | | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
Immediate Cause (Final disease or condition resulting in death)
e. Prostate Cancer, metastatic
Due to (or as a consequence of):
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | |
| 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown | | | | | | | | |
| 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | | | | |
| 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | | |
| 26. Place of Death (Check only one)
Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify) | | | | | | | | |
| 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation
2 <input type="checkbox"/> Accident 8 <input type="checkbox"/> Could not be determined
3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | | | | | | | |
| 28a. Date of Injury (Month, Day, Year)
N/A | | | | | | | | |
| 28b. Time of Injury
M | | | | | | | | |
| 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | | | | |
| 28d. Describe how injury occurred | | | | | | | | |
| 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)
N/A | | | | | | | | |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | |
| 29a. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | |
| 29b. Signature and title of certifier
<i>Robert Hsiao</i> Physician | | | | | | | | |
| 29c. License number
D35305 | | | | | | | | |
| 29d. Date signed (Month, Day, Year)
5-24-96 | | | | | | | | |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)
Robert Hsiao Good Samaritan Hospital Russel Morgan Bldg. Baltimore, Maryland 21239 | | | | | | | | |
| 31. Date filed (Month, Day, Year)
MAY 28 1996 | | | | | | | | |
| 32. Registrar's Signature
<i>Julia Davidson-Randall</i> | | | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene
Certificate of Death

96 15604

Reg. No.

| | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|--|---|----------------------------------|---|--|---|---|---|--|---|---|---|----------------------------------|--------------|----------------------------------|--|----------------------------------|-----------|---|--|----|--|----------------------------------|--|----|--|----------------------------------|--|---|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
<u>Elexora Cole</u> | | | | | 2. Date of Death
Month <u>MAY</u> Day <u>26</u> Year <u>1996</u> | | 3. Time of Death
<u>11:05 am</u> | | | | | | | | | | | | | | | | | | | | |
| | 4a. Facility Name (If not institution, give street and number)
<u>CHURCH HOSPITAL</u> | | | | | 4b. City, Town, or Location of Death
<u>BALTIMORE</u> | | 4c. County of Death
<u>N/A</u> | | | | | | | | | | | | | | | | | | | | |
| Funeral
Director | 5. Social Security Number
<u>216-12-7802 D</u> | | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)
<u>81</u> Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 6. Date of Birth (Month, Day, Year)
<u>MAY 12 1915</u> | | 9. Birthplace (State or Foreign Country)
<u>MARYLAND</u> | | | | | | | | | | | | | | | | | | | |
| | Usual Residence of Decedent | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 10a. State
<u>MD</u> | | | 10b. County
<u>N/A</u> | | 10c. City, Town or Location
<u>Baltimore</u> | | | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | | | | | | | | | | | | | | |
| 10e. Street and Number
<u>2103 W. Mulberry St.</u> | | | | | 10f. Zip Code
<u>21223</u> | | 10g. Citizen of What Country?
<u>USA</u> | | | | | | | | | | | | | | | | | | | | | |
| 11. Marital Status
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc.
Specify: <u>Black</u> | | | | | | | | | | | | | | | | | | | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) <u>6th</u> College (1-4 or 5+) <u></u> | | | | | 15e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
<u>Seamstress</u> | | | 15b. Kind of Business/Industry
<u>A.T. Jones Costumes</u> | | | | | | | | | | | | | | | | | | | | |
| 17. Father's Name (First, Middle, Last)
<u>William Pinkney Pinder</u> | | | | | 18. Mother's Name (First, Middle, Maiden Surname)
<u>Florence Paige</u> | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
<u>Emma Barnes-daughter</u> | | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
<u>6802 Brompton Rd. Baltimore MD 21207</u> | | | | | | | | | | | | | | | | | | | | | | | |
| 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
<u>Baltimore Cemetery</u> | | | 20c. Date
<u>MAY 30 1996</u> | | 20d. Location - City or Town, State
<u>Baltimore, MD</u> | | | | | | | | | | | | | | | | | | | | |
| 21. Signature of Funeral Service Licensee
<u>[Signature]</u> | | | | | 22. Name and Address of Facility
<u>March Funeral Home, West
4300 Wabash Ave. Baltimore, MD 21215</u> | | | | | | | | | | | | | | | | | | | | | | | |
| 23a. Pert 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <table border="0" style="width:100%;"> <tr> <td style="width:30%; vertical-align: top;"> Immediate Cause (Final disease or condition resulting in death)

 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last </td> <td style="width:60%; vertical-align: top;"> <table border="0"> <tr> <td style="width:5%; text-align: center;">a.</td> <td style="width:75%;">SEPTIC SHOCK</td> <td style="width:20%; text-align: center;">Due to (or as a consequence of):</td> <td style="width:10%;"></td> </tr> <tr> <td style="text-align: center;">b.</td> <td>PNEUMONIA</td> <td style="text-align: center;">Due to (or as a consequence of):</td> <td></td> </tr> <tr> <td style="text-align: center;">c.</td> <td></td> <td style="text-align: center;">Due to (or as a consequence of):</td> <td></td> </tr> <tr> <td style="text-align: center;">d.</td> <td></td> <td style="text-align: center;">Due to (or as a consequence of):</td> <td></td> </tr> </table> </td> <td style="width:15%; vertical-align: top;"> Approximate Interval Between Onset and Death

 <u>1 WEEK</u>

 <u>2 WEEKS</u> </td> </tr> </table> | | | | | | | | | | Immediate Cause (Final disease or condition resulting in death)

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last | <table border="0"> <tr> <td style="width:5%; text-align: center;">a.</td> <td style="width:75%;">SEPTIC SHOCK</td> <td style="width:20%; text-align: center;">Due to (or as a consequence of):</td> <td style="width:10%;"></td> </tr> <tr> <td style="text-align: center;">b.</td> <td>PNEUMONIA</td> <td style="text-align: center;">Due to (or as a consequence of):</td> <td></td> </tr> <tr> <td style="text-align: center;">c.</td> <td></td> <td style="text-align: center;">Due to (or as a consequence of):</td> <td></td> </tr> <tr> <td style="text-align: center;">d.</td> <td></td> <td style="text-align: center;">Due to (or as a consequence of):</td> <td></td> </tr> </table> | a. | SEPTIC SHOCK | Due to (or as a consequence of): | | b. | PNEUMONIA | Due to (or as a consequence of): | | c. | | Due to (or as a consequence of): | | d. | | Due to (or as a consequence of): | | Approximate Interval Between Onset and Death

<u>1 WEEK</u>

<u>2 WEEKS</u> |
| Immediate Cause (Final disease or condition resulting in death)

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last | <table border="0"> <tr> <td style="width:5%; text-align: center;">a.</td> <td style="width:75%;">SEPTIC SHOCK</td> <td style="width:20%; text-align: center;">Due to (or as a consequence of):</td> <td style="width:10%;"></td> </tr> <tr> <td style="text-align: center;">b.</td> <td>PNEUMONIA</td> <td style="text-align: center;">Due to (or as a consequence of):</td> <td></td> </tr> <tr> <td style="text-align: center;">c.</td> <td></td> <td style="text-align: center;">Due to (or as a consequence of):</td> <td></td> </tr> <tr> <td style="text-align: center;">d.</td> <td></td> <td style="text-align: center;">Due to (or as a consequence of):</td> <td></td> </tr> </table> | a. | SEPTIC SHOCK | Due to (or as a consequence of): | | b. | PNEUMONIA | Due to (or as a consequence of): | | c. | | Due to (or as a consequence of): | | d. | | Due to (or as a consequence of): | | Approximate Interval Between Onset and Death

<u>1 WEEK</u>

<u>2 WEEKS</u> | | | | | | | | | | |
| a. | SEPTIC SHOCK | Due to (or as a consequence of): | | | | | | | | | | | | | | | | | | | | | | | | | | |
| b. | PNEUMONIA | Due to (or as a consequence of): | | | | | | | | | | | | | | | | | | | | | | | | | | |
| c. | | Due to (or as a consequence of): | | | | | | | | | | | | | | | | | | | | | | | | | | |
| d. | | Due to (or as a consequence of): | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
<u>ACUTE RENAL FAILURE - ACUTE PULMONARY EDEMA - ACUTE RESPIRATORY DISTRESS SYNDROME - HEPATIC FAILURE - ILEUS</u> | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 26. Place of Death (Check only one)
Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
<u>M</u> | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | | | | | | | | | | | | | | | | | | | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | | | | | | | | | | | | | | | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 29b. Signature and title of certifier
<u>[Signature]</u> | | | | | 29c. License number
<u>023308</u> | | 29d. Date signed (Month, Day, Year)
<u>MAY 26 1996</u> | | | | | | | | | | | | | | | | | | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
<u>ALAN SWEATMAN CHURCH HOSPITAL BALTIMORE 21231</u> | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
<u>MAY 28 1996</u> | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 32. Registrar's Signature
<u>[Signature]</u> | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 15605

Certificate of Death

Reg. No.

| | | | | | | | | | |
|--|--|--------------------------|---|--|--|--|--|---|---|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
ROSE RUTH COHN | | | | | 2. Date of Death
Month MAY Day 22 Year 1996 | | 3. Time of Death
9:5 AM | |
| | 4a. Facility Name (If not institution, give street and number)
SINAI HOSPITAL | | | | | 4b. City, Town, or Location of Death
BALTIMORE | | 4c. County of Death
N/A | |
| Funeral
Director | 5. Social Security Number
215-07-1357 | | 6. Sex
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)
93 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth (Month, Day, Year)
JAN. 17, 1903 | | 9. Birthplace (State or Foreign Country)
MARYLAND |
| | Usual Residence of Decedent | | | | | | | | |
| 10a. State
MD | | 10b. County
BALTIMORE | | 10c. City, Town or Location
BALTIMORE | | | 10d. Inside City Limits
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | |
| 10e. Street and Number
3623 SEVEN MILE LA, APT. C-1 | | | | 10f. Zip Code
21208 | | 10g. Citizen of What Country?
USA | | | |
| 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: WHITE | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12
College (1-4or 5+) | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
ACCOUNTING CLERK | | | 16b. Kind of Business/Industry
STATE OF MARYLAND | | | |
| 17. Father's Name (First, Middle, Last)
WILLIAM ZETLIN | | | | 18. Mother's Name (First, Middle, Maiden Surname)
LENA UNKNOWN | | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
L. MARC COHN (SON) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
19808 BILLINGS CT. GAITHERSBURG, MD 20879 | | | | | |
| 20a. Method of Disposition
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
BALTIMORE HEBREW | | Data
5/23/96 | 20c. Location - City or Town, State
BALTIMORE, MD | | | |
| 21. Signature of Funeral Service Licensee
Ellen Sue Lewinson | | | | 22. Name and Address of Facility
SOL LEVINSON & BROS., INC.
8900 REISTERSTOWN RD., PIKESVILLE, MD 21208 | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
Immediate Cause (Final disease or condition resulting in death)
a. LUNG CANCER, PATHOLOGY UNKNOWN
Due to (or as a consequence of):
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last | | | | | | | | | Approximate Interval Between Onset and Death
2 YEARS |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
PAROXYSMAL ATRIAL FIBRILLATION | | | | | | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown | | | |
| | | | | | | 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | 26. Place of Death (Check only one)
Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation
2 <input type="checkbox"/> Accident 8 <input type="checkbox"/> Could not be determined
3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred |
| | | | 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | |
| 29b. Signature and title of certifier
Jennifer Park MD | | | | 29c. License number
AS2402321-JP-9937 | | 29d. Date signed (Month, Day, Year)
May 22, 1996 | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Jennifer Park MD Sinai Hospital 2401 W. Belvedere Ave Baltimore, MD 21209 | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
MAY 28 1996 | | | 32. Registrar's Signature
Julia Anderson-Randall | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

1. The first part of the report is a general
description of the project and its objectives.
It includes a brief history of the project and
a statement of the problem to be solved.

2. The second part of the report is a
detailed description of the methodology used
in the study. This includes a description of
the data collection methods and the statistical
techniques used to analyze the data.

3. The third part of the report is a
discussion of the results of the study. This
includes a description of the findings and
an interpretation of the results in the context
of the research objectives.

4. The fourth part of the report is a
conclusion and a list of references. The
conclusion summarizes the main findings of
the study and provides a final statement of
the project's significance. The references
list the sources of information used in the
study.

96 15606

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | | | | | |
|--|--|---|--|--|--|--|--|--|---|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
GILBERT COLLINS | | | | 2. DATE OF DEATH
MONTH MAY DAY 23 YEAR 1996 | | | | 3. TIME OF DEATH
3:10 A.M. | | | | | |
| 4. SOCIAL SECURITY NUMBER
217-12-9677 | | 5. SEX
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | 6. AGE (In yrs. last birthday)
74 YRS. | IF UNDER 1 YEAR
MONTHS 0 DAYS 0 | | IF UNDER 24 HRS.
HOURS 0 MIN. 0 | | 7. DATE OF BIRTH
Month, Day, Year
Oct. 16, 1921 | | 8. BIRTHPLACE (State or Foreign Country)
Maryland | | | |
| 9a. FACILITY NAME (If not institution, give street and number)
Deaton Nursing Center | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
Baltimore | | | | 9c. COUNTY OF DEATH
N/A | | | | | |
| 10a. STATE
Maryland | | | | 10b. COUNTY
N/A | | 10c. CITY, TOWN OR LOCATION
Baltimore | | | | 10d. INSIDE CITY LIMITS?
<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | | |
| 10e. STREET AND NUMBER
701 N. Carrollton Ave. Apt. 306 | | | | 10f. ZIP CODE
21217 | | | | 10g. CITIZEN OF WHAT COUNTRY?
USA | | | | | |
| 11. MARITAL STATUS
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO
IF YES, GIVE WAR OR DATES
WWII | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | | | 14. RACE — American Indian, Black, White, etc.
Specify: Negro | | | | | |
| 15. DECEDENT'S EDUCATION
(Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (1-4 or 5+) 0 | | | | 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of life. Do NOT use retired.)
Railroad Porter | | | | 16b. KIND OF BUSINESS/INDUSTRY
Transportation | | | | | |
| 17. FATHER'S NAME (First, Middle, Last)
Charles E. Campbell Sr. | | | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Lillie Queen | | | | | | | |
| 19a. INFORMANT'S NAME (Type/Print)
Ms. Crystalle Campbell | | | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
704 Lelia Ct. Bel Air, Md. 21014 | | | | | | | |
| 20a. METHOD OF DISPOSITION
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
Louisa Park 5/28/96 Balto, Md. | | | | 20c. LOCATION — City or Town, State | | | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
Joseph L. Russ | | | | | | 22. NAME AND ADDRESS OF FACILITY
Joseph L. Russ Funeral Home
2222 W. North Ave. Balto, Md. 21216 | | | | | | | |
| 23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

IMMEDIATE CAUSE (Final disease or condition resulting in death) → Sepsis

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

a. Infected Decubitus Ulcers of heels
b. End Stage Parkinson's Disease
c. Stroke
d. Heart Arrhythmia | | | | | | | | | | Approximate interval Between Onset and Death
2 wks
2 months
10 years | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Stroke
Heart Arrhythmia | | | | | | | | | | 24a. WAS AN AUTOPSY PERFORMED?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
<input type="checkbox"/> YES <input type="checkbox"/> NO | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA
OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | | | |
| 27. MANNER OF DEATH
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation
<input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Could not be determined | | | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M 1 | | 28c. INJURY AT WORK?
<input type="checkbox"/> YES <input type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | | | |
| 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. CERTIFIER (Check only one)
<input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
MD | | | | | | 29c. LICENSE NUMBER
A3875 | | | 29d. DATE SIGNED (Month, Day, Year)
5/23/96 | | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
JOEL MESHULAM 1147 S HANOVER ST BALT MD 21230 | | | | | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
MAY 28 1996 | | | | 32. REGISTRAR'S SIGNATURE
[Signature] | | | | | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 15607

Certificate of Death

Reg. No.

| | | | | | | | | | | | | | | |
|--|--|--|---|---|--|--|--------------------------------|--------------------------------------|--|--|--|-----------------------------------|---|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
<i>cleora coeater</i> | | | | 2. Date of Death
Month <i>5</i> Day <i>21</i> Year <i>96</i> | | | | 3. Time of Death
<i>7:12 P.M</i> | | | | | |
| | 4a. Facility Name (If not institution, give street and number)
<i>Bon Secour Hospital</i> | | | | 4b. City, Town, or Location of Death
<i>Baltimore</i> | | | | 4c. County of Death
<i>N/A</i> | | | | | |
| Funeral
Director | 5. Social Security Number
<i>220-30-0894</i> | | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday)
<i>86</i> Yrs. | | If Under 1 Year
Months Days | | If Under 24 Hrs.
Hours Min. | | 8. Date of Birth
(Month, Day, Year)
<i>March 7, 1910</i> | | 9. Birthplace (State or Foreign Country)
<i>South Carolina</i> | |
| | Usual Residence of Decedent | | | | | | | | | | | | | |
| To Be Completed by Funeral Director | 10a. State
<i>Maryland</i> | | 10b. County
<i>N/A</i> | | 10c. City, Town or Location
<i>Baltimore</i> | | | | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | | |
| | 10e. Street and Number
<i>1205 Poplar Grove</i> | | | | 10f. Zip Code
<i>21216</i> | | | | 10g. Citizen of What Country?
<i>USA</i> | | | | | |
| | 11. Marital Status
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever In U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | | 14. Race - American Indian, Black, White, etc.
Specify: <i>Negro</i> | | | | | |
| | 15. Decedent's Education
(Specify only highest grade completed)
Elementary/Secondary (0-12) <i>7</i> College (1-4or 5+) <i>0</i> | | | | 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)
<i>Domestic Worker</i> | | | | 16b. Kind of Business/Industry
<i>Outside Home</i> | | | | | |
| | 17. Father's Name (First, Middle, Last)
<i>Jim Atkins</i> | | | | 18. Mother's Name (First, Middle, Maiden Surname)
<i>Jannie Atkins</i> | | | | | | | | | |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print)
<i>Mrs. Cybel Tilghman</i> | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
<i>2824 Winchester St. Balto. Md. 21216</i> | | | | | | | | | |
| | 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
<i>Mt. Zion</i> | | | | 20c. Location - City or Town, State
<i>5/28/96 Lansdowne, Md.</i> | | | | | |
| | 21. Signature of Funeral Service Licensee
<i>Joseph L. Russ</i> | | | | 22. Name and Address of Facility
<i>Joseph L. Russ Funeral Home
2222 W. North Ave. Balto. Md. 21216</i> | | | | | | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
<i>a. arrhythmia</i>
Due to (or as a consequence of):
<i>b. atherosclerotic Cardiovascular disease</i>
Due to (or as a consequence of):
<i>c.</i>
Due to (or as a consequence of):
<i>d.</i> | | | | | | | | | | | | | |
| | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | | | | | | | | | | | | |
| 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | | | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | | | | | | | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | | | | | | | |
| 26. Place of Death (Check only one)
Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | | | | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation
<input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined
<input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | | | 28a. Date of Injury (Month, Day, Year) | | | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input type="checkbox"/> No | | 28d. Describe how Injury occurred | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | 29b. Signature and title of certifier
<i>Joseph L. Russ M.D.</i> | | | | 29c. License number
<i>D39127</i> | | 29d. Date signed (Month, Day, Year)
<i>5/22/96</i> | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
<i>A. AHMED MD 300 Army place Baltimore MD 21201</i> | | | | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
<i>MAY 28 1996</i> | | | | 32. Registrar's Signature
<i>James Davidson</i> | | | | | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 15608

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

John V. Cook, Jr.

2. Date of Death

May 27, 1996

3. Time of Death

6:00 A.M.

4a. Facility Name (If not institution, give street and number)

8401 Horatio Rd.

4b. City, Town, or Location of Death

Randallstown

4c. County of Death

Baltimore

Funeral
Director

5. Social Security Number

217 54 4957

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

47

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Dec. 7, 1948

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Randallstown

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

8401 Horation Rd.

10f. Zip Code

21133

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4or 5+)

12

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Hairstylist

16b. Kind of Business/Industry

Salon

17. Father's Name (First, Middle, Last)

John Vernon

18. Mother's Name (First, Middle, Maiden Surname)

Mariam (unknown)

19a. Informant's Name/Relationship (Type, Print)

Jeffrey D. Porta . companion

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

8401 Horatio Rd., Randallstown, MD 21133

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Green Mount Crematory 5/28/96

Date

20c. Location - City or Town, State

Baltimore, MD

21. Signature of Funeral Service Licensee

Stephen D. Lohrmann

22. Name and Address of Facility

CAFA Stephen D. Lohrmann P.A.
8717 Green Pastures Dr., Baltimore, MD 21286

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Cardiopulmonary arrest
Due to (or as a consequence of):
Atherosclerosis

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):
Hypertension
Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Stephen D. Lohrmann

29c. License number

P 30339

29d. Date signed (Month, Day, Year)

5/28/96

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

NICAN WISTER, DO 19 WALKER AVE, BALTIMORE, MD 21208

31. Date filed (Month, Day, Year)

MAY 28 1996

32. Registrar's Signature

John W. Winder-Randall

State
Registrar

Baltimore, Maryland 21215-0020

permits. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

1. The first part of the report deals with the general situation of the country and the progress of the work during the year.

2. The second part of the report deals with the results of the work during the year and the progress of the work during the year.

3. The third part of the report deals with the results of the work during the year and the progress of the work during the year.

4. The fourth part of the report deals with the results of the work during the year and the progress of the work during the year.

5. The fifth part of the report deals with the results of the work during the year and the progress of the work during the year.

6. The sixth part of the report deals with the results of the work during the year and the progress of the work during the year.

7. The seventh part of the report deals with the results of the work during the year and the progress of the work during the year.

8. The eighth part of the report deals with the results of the work during the year and the progress of the work during the year.

9. The ninth part of the report deals with the results of the work during the year and the progress of the work during the year.

10. The tenth part of the report deals with the results of the work during the year and the progress of the work during the year.

11. The eleventh part of the report deals with the results of the work during the year and the progress of the work during the year.

12. The twelfth part of the report deals with the results of the work during the year and the progress of the work during the year.

13. The thirteenth part of the report deals with the results of the work during the year and the progress of the work during the year.

14. The fourteenth part of the report deals with the results of the work during the year and the progress of the work during the year.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 15609

Certificate of Death

Reg. No.

| | | | | | | | | | |
|---|---|---|--|---|---|--|--|-----------------------------------|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
DONELL RAYVON CARPENTER | | | | 2. Date of Death
Month Day Year
MAY 24, 1996 | | 3. Time of Death
11:40 | | |
| | 4a. Facility Name (If not Institution, give street and number)
THE JOHNS HOPKINS HOSPITAL | | | | 4b. City, Town, or Location of Death
BALTIMORE CITY | | 4c. County of Death
N/A | | |
| Funeral
Director | 5. Social Security Number
217-60-4552 | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday)
42 Yrs. | | 8. Date of Birth (Month, Day, Year)
JAN. 21, 1954 | | |
| | 9. Birthplace (State or Foreign Country)
NORTH CAROLINA | | | | | | | | |
| Usual Residence of Decedent | | | | | | | | | |
| 10a. State
MARYLAND | | 10b. County
N/A | | 10c. City, Town or Location
BALTIMORE CITY | | | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | |
| 10e. Street and Number
2627 KIRK AVENUE | | | | 10f. Zip Code
21218 | | 10g. Citizen of What Country?
U.S.A. | | | |
| 11. Marital Status
<input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No JULY 10/73
If Yes, Give Year or Dates: APR. 14/77 | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: BLACK | | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12TH
College (1-4 or 5+) N/A | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
MAIL HANDLER | | 16b. Kind of Business/Industry
U.S. POSTAL SERVICE | | | |
| 17. Father's Name (First, Middle, Last)
RICHARD CONNER | | | | 18. Mother's Name (First, Middle, Maiden Surname)
OZELLE CARPENTER | | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
OZELLE HOLMES-MOTHER | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
2627 KIRK AVE. BALTO, MD. 21218 | | | | | |
| 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
MAY 30, 1996
GARRISON FOREST VET. CEM | | 20c. Location - City or Town, State
OWINGS MILLS, MD. | | | | | |
| 21. Signature of Funeral Service Licensee
<i>Calvin B. Scruggs, Jr.</i> | | | | 22. Name and Address of Facility
CALVIN B. SCRUGGS FUNERAL HOME
1412 E. PRESTON ST. BALTO, MD. 21213 | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. INTRACRANIAL HEMORRHAGE
Due to (or as a consequence of):

b. HYPERTENSION
Due to (or as a consequence of):

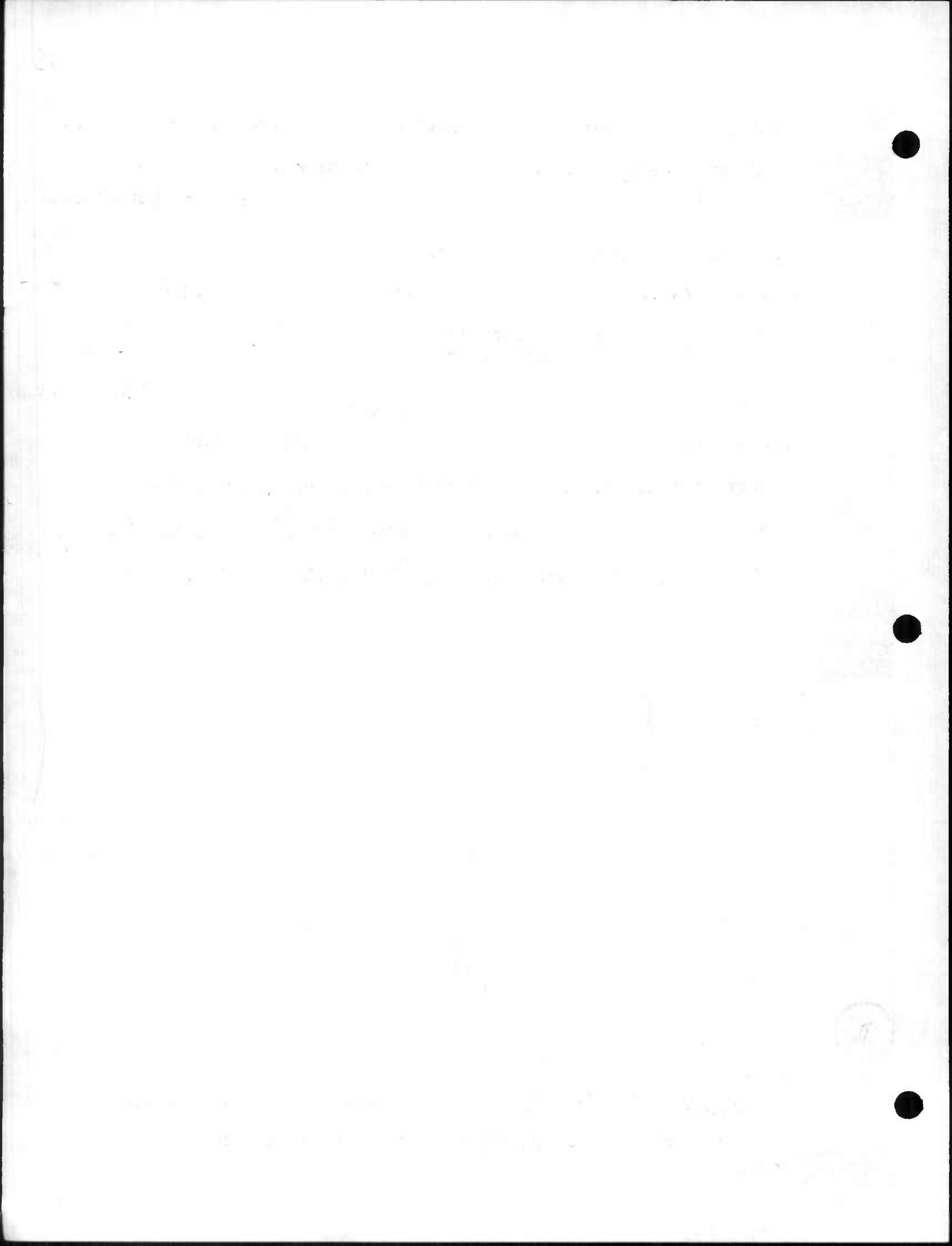
c.
Due to (or as a consequence of):

d.
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | | | |
| 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | | | | | | | | |
| 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | | |
| 26. Place of Death (Check only one)
Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input type="checkbox"/> No | | 28d. Describe how injury occurred | |
| 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | |
| 29b. Signature and title of certifier
<i>Velma Joseph</i> | | | | 29c. License number
N4067 | | 29d. Date signed (Month, Day, Year)
MAY 24, 1996 | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
VELMA JOSEPH 600 NORTH LAFAYETTE STREET BALTIMORE, MD 21287 | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
MAY 28 1996 | | | | 32. Registrar's Signature
<i>John Anderson</i> | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



96 15610

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | |
|---|--|--|--|--|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
Dorothy Eloise Clayton | | | | 2. DATE OF DEATH
May 26, 1996 | | | | 3. TIME OF DEATH
9:00 P.M. | |
| 4. SOCIAL SECURITY NUMBER
215-01-9750 | | 5. SEX
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
87 YRS. | | 7. DATE OF BIRTH
(Month, Day, Year)
Sept. 11, 1908 | | 8. BIRTHPLACE (State or Foreign Country)
Maryland | |
| 9a. FACILITY NAME (If not institution, give street and number)
305 E. Joppa Rd. | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
Towson | | | | 9c. COUNTY OF DEATH
Baltimore | |
| RESIDENCE OF DECEDENT | | | | | | | | | |
| 10a. STATE
Md. | | 10b. COUNTY
Baltimore | | 10c. CITY, TOWN OR LOCATION
Towson | | | | 10d. INSIDE CITY LIMITS?
1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 10a. STREET AND NUMBER
305 E. Joppa Rd. | | | | 10f. ZIP CODE
21286 | | | | 10g. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 11. MARITAL STATUS
1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yea or No—
If yea, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | | | 14. RACE — American Indian, Black, White, etc.
Specify: White | |
| 15. DECEDENT'S EDUCATION
(Specify only highest grade completed)
Elementary 8 Secondary (9-12) College (1-4 or 5 +) | | | | 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.)
Seamstress | | | | 16b. KIND OF BUSINESS/INDUSTRY
Custom Clothing | |
| 17. FATHER'S NAME (First, Middle, Last)
Joseph B. Clayton | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Emma Heiss | | | | | |
| 19a. INFORMANT'S NAME (Type/Print)
George Maynard | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
219 Berrymans Lane, Reisterstown, Md. 21136 | | | | | |
| 20a. METHOD OF DISPOSITION
1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
Green Mount Cemetery May 28, 1996 | | | | 20c. LOCATION — City or Town, State
Baltimore, Md. | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
H. J. Eckhardt | | | | 22. NAME AND ADDRESS OF FACILITY
Eckhardt Funeral Chapel 21117
11605 Reisterstown Rd., Owings Mills, Md. | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>Arteriosclerotic Cardio Renal</u>
Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { b. <u>Vascular Disease</u>
c.
d.
DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | Approximate Interval Between Onset and Death | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | 24a. WAS AN AUTOPSY PERFORMED?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/> | | | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA
OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation
2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined
3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | | | 28a. DATE OF INJURY
(Month, Day, Year) | | 28b. TIME OF INJURY
M | | 28c. INJURY AT WORK?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| | | | | 28d. DESCRIBE HOW INJURY OCCURRED | | | | 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. CERTIFIER (Check only one)
1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
Charles F. O'Donnell MD | | | | 29c. LICENSE NUMBER
D-09383 | | | | 29d. DATE SIGNED (Month, Day, Year)
May 27, 1996 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (Item 27) (Type, Print)
Charles F. O'Donnell MD - 1114 Hamlet Hill Rd Baltimore MD 21210 | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
MAY 28 1996 | | | | 32. REGISTRAR'S SIGNATURE
John Davidson-Randall | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 6876 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 15611

Certificate of Death

Reg. No.

| | | | | | | | | |
|---|--|---|---|--|---|---|---|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
APOLINARY VINCENT CARBONE | | | | 2. Date of Death
Month 5 Day 24 Year 96 | | 3. Time of Death
5:55 AM | |
| | 4a. Facility Name (If not institution, give street and number)
509 Joppa Farm Rd. | | | | 4b. City, Town, or Location of Death
Joppatowne | | 4c. County of Death
Harford | |
| Funeral
Director | 5. Social Security Number
215-28-3601 | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)
65 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth (Month, Day, Year)
Aug. 17, 1930 | 9. Birthplace (State or Foreign Country)
Maryland |
| | Usual Residence of Decedent | | | | | | | |
| To Be Completed by Funeral Director | 10a. State
MD. | | 10b. County
Harford | | 10c. City, Town or Location
Joppatowne / Joppa | | | 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| | 10e. Street and Number
509 Joppa Farm Rd. | | | | 10f. Zip Code
21085 | | 10g. Citizen of What Country?
USA | |
| | 11. Marital Status
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input type="checkbox"/> No
If Yes, Give Year or Dates: 1967-1971 | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: White | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 yrs. College (1-4 or 5+) 2 yrs. | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Radiation Technician | | 16b. Kind of Business/Industry
Civilian-APG | |
| | 17. Father's Name (First, Middle, Last)
Samuel Carbone | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Caroline Lisowski | | | |
| | 19a. Informant's Name/Relationship (Type, Print)
Patricia M. Carbone | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
509 Joppa Farm Rd. Joppa, Maryland 21085 | | | |
| | 20a. Method of Disposition
<input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Metro Crematory Inc. | | Date
5-24-96 | | 20c. Location - City or Town, State
Baltimore, Md. | |
| | 21. Signature of Funeral Service Licensee
<i>Heather Lassahn</i> | | | | 22. Name and Address of Facility
E. F. Lassahn Funeral Home 11750 Belair Rd. Kingsville, Md. 21087 | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. METASTATIC LUNG CANCER
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of): | | | | | | | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | |
| 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | | | | |
| 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how Injury occurred |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | |
| 29b. Signature and title of certifier
<i>Sh. Pura</i> | | | | 29c. License number
019717 | | 29d. Date signed (Month, Day, Year)
5/24/96 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
MICHAEL ANTON, 4440 EMBURY AVE, BALTIMORE, MD 21224 | | | | | | | | |
| 31. Date filed (Month, Day, Year)
MAY 28 1996 | | 32. Registrar's Signature
<i>Julia Harrison-Randall</i> | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

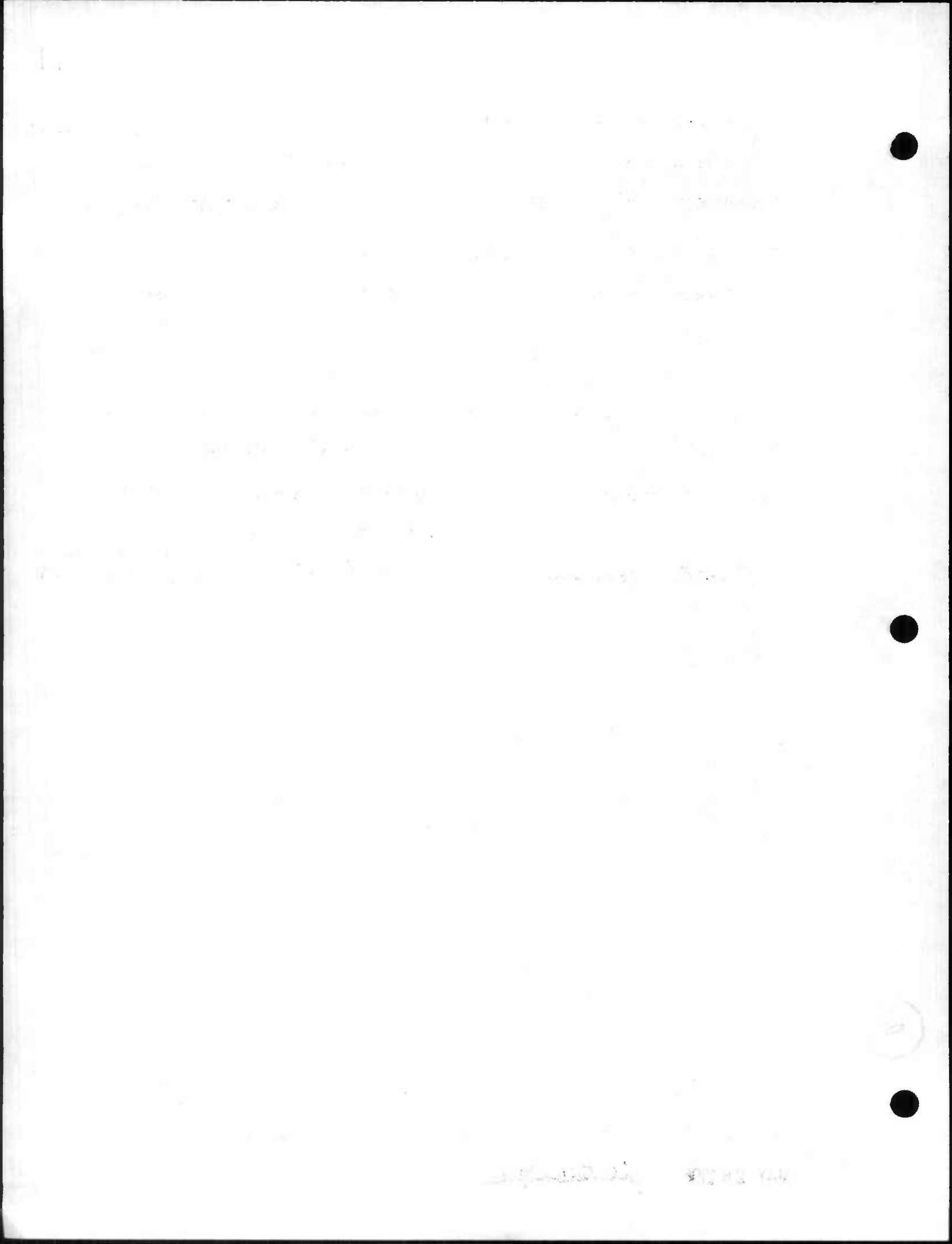
Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene
Certificate of Death

96 15612

Reg. No.

| | | | | | | | | | |
|--|--|---|--|---|---|---|---|--|--|
| Physician
/Medical
Examiner | 1. Decedant's Name (First, Middle, Last)
Raymond E. Cross | | | 2. Date of Death
Month 5 Day 24 Year 96 | | 3. Time of Death
1245AM | | | |
| | 4a. Facility Name (If not institution, give street and number)
1117 Armistead Street | | | 4b. City, Town, or Location of Death
Glen Burnie | | 4c. County of Death
Anne Arundel | | | |
| Funeral
Director | 5. Social Security
219-20-5697 Sex M | | 7. Age (In yrs. last birthday)
69 Yrs. | | 8. Date of Birth (Month, Day, Year)
9/28/26 | | 9. Birthplace (State or Foreign Country)
MARYLAND | | |
| | Usual Residence of Decedent | | | 10f. Zip Code
21061 | | 10g. Citizen of What Country?
U.S.A. | | 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 10a. State
MARYLAND | | 10b. County
ANNE ARUNDEL | | 10c. City, Town or Location
GLEN BURNIE | | 10e. Street and Number
1117 ARMISTEAD STREET | | 10f. Zip Code
21061 | |
| 11. Marital Status
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: WHITE | | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 8 College (1-4or 5+) NONE | |
| 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
SUPERVISOR | | 16b. Kind of Business/Industry
WESTINGHOUSE | | 17. Father's Name (First, Middle, Last)
JOSHUA S. CROSS | | 18. Mother's Name (First, Middle, Maiden Surname)
RUBY M. JOHNSON | | 19a. Informant's Name/Relationship (Type, Print)
MRS. ELIZABETH C. CROSS | |
| 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1117 ARMISTEAD STREET, GLEN BURNIE, MD 21061 | | 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
LOUDON PARK | | 20c. Location - City or Town, State
5/28/96 BALTIMORE, MARYLAND | | 21. Signature of Funeral Service Licensee
 | |
| 22. Name and Address of Facility
SINGLETON FUNERAL HOME
1 SECOND AVE. S.W., GLEN BURNIE, MD 21061 | | 23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. ACUTE ANTERIOR WALL MYOCARDIAL INFARCTION
Due to (or as a consequence of):
b. CEREBROVASCULAR ACCIDENT
Due to (or as a consequence of):
c. HYPERTENSION
Due to (or as a consequence of):
d. INSULIN DEPENDENT DIABETES MELLITUS | | Approximate Interval Between Onset and Death
13 DAYS
1 MONTH
5 YEARS
2 YEARS | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year)
MAY 24, 1996 | |
| 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how Injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier
 | | 29c. License number
D28221 | | 29d. Date signed (Month, Day, Year)
MAY 24, 1996 | | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
DAN H. SCHREIBER, MD 301 HOSPITAL DRIVE, GLEN BURNIE MARYLAND | |
| 31. Date filed (Month, Day, Year)
MAY 28 1996 | | 32. Registrar's Signature
 | | 33. Registrar's Name
21061 | | 34. Registrar's Title
21061 | | 35. Registrar's Address
21061 | |

Baltimore, Maryland 21215-0020

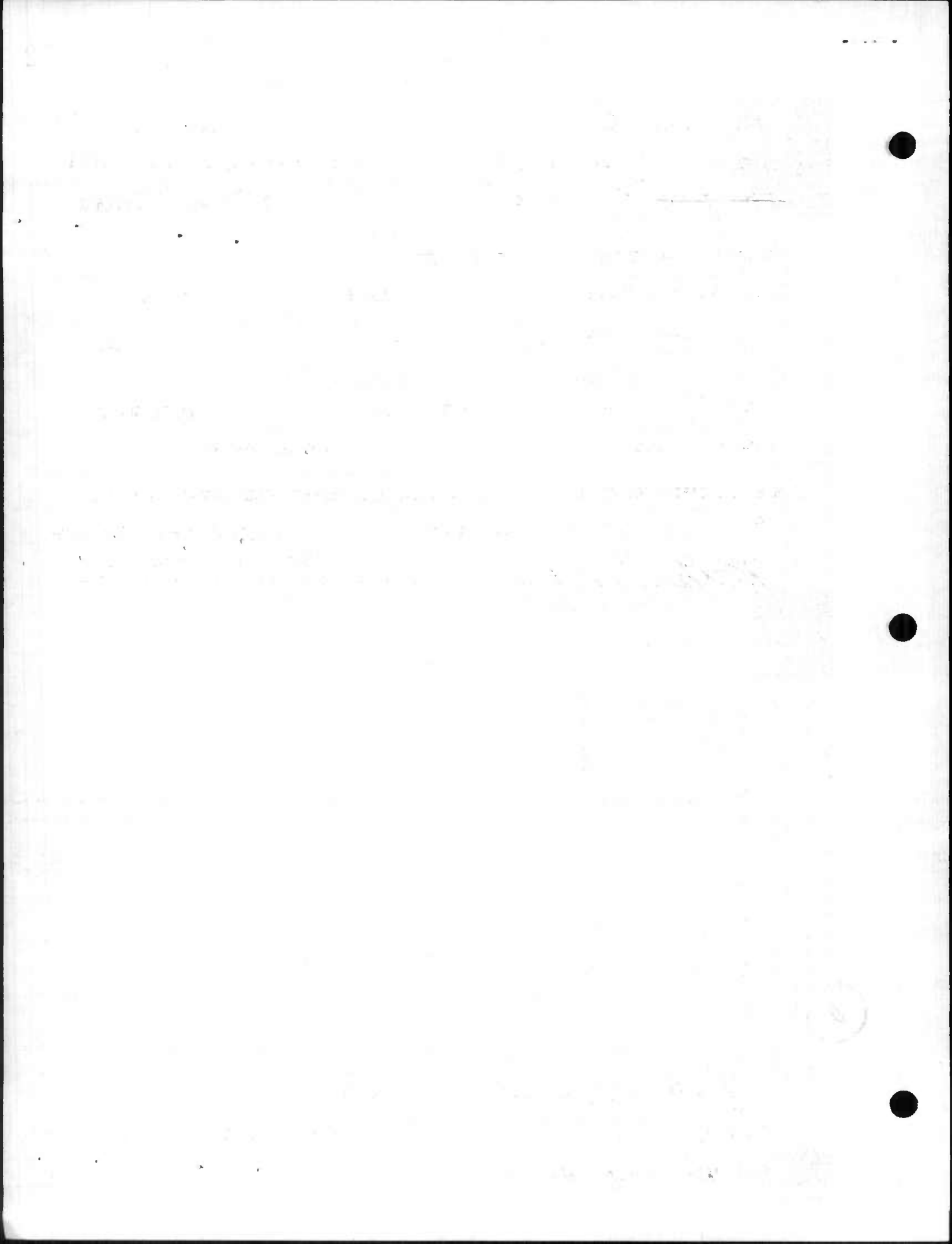
Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed, it must be filed by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene
Certificate of Death

96 15613

Reg. No.

| | | | | | | | | |
|---|---|---|---|---|--|--|--|---|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
DAVID JOSEPH CHURCH | | | | 2. Date of Death
Month MAY Day 23 Year 1996 | | 3. Time of Death
12:30 AM | |
| | 4a. Facility Name (If not institution, give street and number)
1042 THOMAS ROAD | | | | 4b. City, Town, or Location of Death
GLEN BURNIE | | 4c. County of Death
ANNE ARUNDEL | |
| Funeral
Director | 5. Social Security Number
220-58-1993 | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (in yrs. last birthday)
40 Yrs. | If Under 1 Year
Months Days | 8. Date of Birth
(Month, Day, Year)
MAY 28, 1955 | 9. Birthplace (State or Foreign Country)
MARYLAND | |
| | Usual Residence of Decedent | | | | | | | |
| 10a. State
MARYLAND | | 10b. County
ANNE ARUNDEL | | 10c. City, Town or Location
GLEN BURNIE | | | 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 10e. Street and Number
1042 THOMAS ROAD | | | | 10f. Zip Code
21060 | | 10g. Citizen of What Country?
U.S.A. | | |
| 11. Marital Status
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced | | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: WHITE | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 11 College (1-4 or 5+) N/A | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
N/A | | 16b. Kind of Business/Industry
N/A | | |
| 17. Father's Name (First, Middle, Last)
OMER CHURCH | | | | | 18. Mother's Name (First, Middle, Maiden Surname)
ELIZABETH BENNOIT | | | |
| 19a. Informant's Name/Relationship (Type, Print)
ELIZABETH J. GRUBE | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
210 DAFFODEL RD., GLEN BURNIE, MD 21060 | | | | |
| 20a. Method of Disposition
<input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
CHESAPEAKE CREMATORY INC. | | Date
5/28/96 | 20c. Location - City or Town, State
BELTSVILLE, MARYLAND | | |
| 21. Signature of Funeral Service Licensee
 | | | | 22. Name and Address of Facility
SINGLETON FUNERAL HOME
1 SECOND AVE. S.W., GLEN BURNIE, MD 21061 | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. acute M.I.
Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last | | | | | | | | Approximate Interval Between Onset and Death
UNKNOWN |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | |
| | | | | | | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input type="checkbox"/> No | | 28d. Describe how injury occurred |
| 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | |
| 29b. Signature and title of certifier
 | | | | 29c. License number
D22110 | | 29d. Date signed (Month, Day, Year)
MAY 24, 1996 | | |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)
MARC A. KAPLAN M.D. 7845 OAKWOOD Rd #300 Glen Burnie | | | | | | | | |
| 31. Date filed (Month, Day, Year)
MAY 28 1996 | | | | | | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 15614

| | | | | | | | | |
|---|--|---|--|---|---|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Sister Mary Gilbert Carney | | | | 2. Date of Death
Month MAY Day 23 Year 96 | | 3. Time of Death
11:15 a.m. | |
| | 4a. Facility Name (If not institution, give street and number)
Bon Secour Provincial House | | | | 4b. City, Town, or Location of Death
Marriottsville | | 4c. County of Death
Howard | |
| Funeral
Director | 5. Social Security Number
034-40-7362 | | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)
87 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth (Month, Day, Year)
Nov. 18, 1908 | 9. Birthplace (State or Foreign Country)
Ireland |
| | Usual Residence of Decedent | | | | | | | |
| 10a. State
Md. | | 10b. County
Howard | | 10c. City, Town or Location
Marriottsville | | | 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 10e. Street and Number
1525 Marriottsville Road | | | | 10f. Zip Code
21104 | | 10g. Citizen of What Country?
U.S.A. | | |
| 11. Marital Status
<input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc.
Specify: White | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) College (1-4 or 5+) 3+ | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Nurse | | | 16b. Kind of Business/Industry
Health Care | |
| 17. Father's Name (First, Middle, Last)
Michael Carney | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Bridget Clark | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
Sr. Margaret Mathewson | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1525 Marriottsville Road Marriottsville, Md. 21104 | | | | |
| 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
May 24, 1996
New Cathedral Cemetery | | | 20c. Location - City or Town, State
Baltimore, Maryland | |
| 21. Signature of Funeral Service Licensee
 | | | | 22. Name and Address of Facility
Witzke Funeral Homes, Inc.
1630 Edmondson Avenue Catonsville, Maryland 21228 | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. Congestive Heart Failure
Due to (or as a consequence of):
b. Ischemic Heart Disease
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | | Approximate Interval Between Onset and Death |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Pneumonia | | | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | |
| | | | | | | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | |
| 29b. Signature and title of certifier
Daliah Shamsuddin M.D. | | | | 29c. License number
D20252 | | 29d. Date signed (Month, Day, Year)
May 23, 1996 | | |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)
D. SHAMSUDDIN M.D. 20 CROSSROADS DRIVE OWINGS MILLS | | | | | | | | |
| 31. Date filed (Month, Day, Year)
MAY 28 1996 | | | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

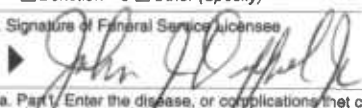
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

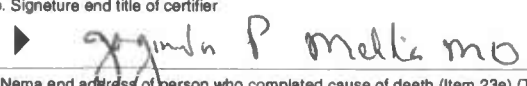
State of Maryland / Department of Health and Mental Hygiene

96 15615

Certificate of Death

Reg. No.

| | | | | | | | | |
|---|--|---|--|--|---|--|---|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
DOROTHY CORSON | | | | 2. Date of Death
Month Day Year
MAY 24, 1996 | | 3. Time of Death
6:10 AM | |
| | 4a. Facility Name (If not institution, give street and number)
ST. JOSEPH MEDICAL CENTER | | | | 4b. City, Town, or Location of Death
TOWSON | | 4c. County of Death
BALTIMORE | |
| Funeral
Director | 5. Social Security Number
217-60-4429 | | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday)
87 Yrs. | | 8. Date of Birth (Month, Day, Year)
July 27, 1908 | |
| | 9. Birthplace (State or Foreign Country)
Maryland | | 10a. State
MD | | 10b. County
Baltimore | | 10c. City, Town or Location
Towson | |
| 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 10e. Street and Number
910 Shelly Road | | 10f. Zip Code
21206 | | 10g. Citizen of What Country?
U.S.A. | | |
| 11. Marital Status
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: White | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (1-4or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Homemaker | | 16b. Kind of Business/Industry
Home | | | | |
| 17. Father's Name (First, Middle, Last)
John Carroll Hammen | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Clara Myrtle | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
Rick Fallin | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
910 Shelly Road Towson, Maryland 21286 | | | | |
| 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Woodlawn Cemetery | | 20c. Location - City or Town, State
5/28/96 Baltimore, Maryland | | | | |
| 21. Signature of Funeral Service licensee
 | | | | 22. Name and Address of Facility
The Dippel Funeral Home Inc.
7110 Belair Road Baltimore, Maryland 21206 | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
CEREBROVASCULAR ACCIDENT
Due to (or as a consequence of):
ASPIRATION PNEUMONIA
Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
5 DAYS
5 DAYS | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
MULTI-INFARCT DEMENTIA | | | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | |
| | | | | | | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 25. Was case referred to medical examiner?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 28d. Describe how injury occurred | | | | 28e. Location (Street and Number or Rural Route Number, City or Town, State) | | | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | |
| 29b. Signature and title of certifier
 | | | | 29c. License number
041410 | | 29d. Date signed (Month, Day, Year)
MAY 24th, 96. | | |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)
JOGINDER P. MEHTA, M.D., 7620 YORK ROAD, TOWSON, MARYLAND 21204 | | | | | | | | |
| 31. Date of Death (Month, Day, Year)
MAY 28 1996 | | | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

96 15616

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | |
|---|--|--|--|---|--|--|--|---|--|
| 1. DECEASED'S NAME (First, Middle, Last)
JOSEPH FRANKLIN DEISE | | | | 2. DATE OF DEATH
MONTH DAY YEAR
May 26, 1996 | | | | 3. TIME OF DEATH
3:05A M | |
| 4. SOCIAL SECURITY NUMBER
213-10-8964 | | 5. SEX
1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
80 YRS. | | 7. DATE OF BIRTH (Month, Day, Year)
09 24 15 | | 8. BIRTHPLACE (State or Foreign Country)
Maryland | |
| 9a. FACILITY NAME (If not institution, give street and number)
VA Maryland Health Care Systems | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
Perry Point | | | | 9c. COUNTY OF DEATH
Cecil | |
| RESIDENCE OF DECEASED | | | | | | | | | |
| 10a. STATE
Md | | 10b. COUNTY
Harford | | 10c. CITY, TOWN OR LOCATION
Edgewood | | | | 10d. INSIDE CITY LIMITS?
1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER
103 Palmetto Drive | | | | 10f. ZIP CODE
21040 | | 10g. CITIZEN OF WHAT COUNTRY?
USA | | | |
| 11. MARITAL STATUS
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEASED EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO
IF YES, GIVE WAR OR DATES
W.W.2 | | 13. WAS DECEASED OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | | | 14. RACE — American Indian, Black, White, etc.
Specify: White | |
| 15. DECEASED'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12) 8 College (1-4 or 5+) 8 | | | | 16a. DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
Painter | | 16b. KIND OF BUSINESS/INDUSTRY
Factory | | | |
| 17. FATHER'S NAME (First, Middle, Last)
William Arthur Deise | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Mary Brosh | | | | | |
| 19a. INFORMANT'S NAME (Type/Print)
Geraldine A. Blacker, Daughter | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
103 Palmetto Dr. Edgewood, Md. 21040 | | | | | |
| 20a. METHOD OF DISPOSITION
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
Maryland Veterans Cem. 5-29-96 | | 20c. LOCATION — City or Town, State
Garrison Forest, Md | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
Charles S. Zeiler | | | | 22. NAME AND ADDRESS OF FACILITY
Charles S. Zeiler & Son Inc.
6224 Eastern Ave. Balto., Md. | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Carcinoma of Lung with Metastasis
DUE TO (OR AS A CONSEQUENCE OF):
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST
b. DUE TO (OR AS A CONSEQUENCE OF):
c. DUE TO (OR AS A CONSEQUENCE OF):
d. | | | | | | | | Approximate Interval Between Onset and Death
1 month | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | 24a. WAS AN AUTOPSY PERFORMED?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/> | | | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA
OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. MANNER OF DEATH
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation
2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide
3 <input type="checkbox"/> Homicide 7 <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M | | 28c. INJURY AT WORK?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| 29a. CERTIFIER (Check only one)
1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
THOMAS FINUCAN, M.D. | | | | 29c. LICENSE NUMBER
D32395 | | 29d. DATE SIGNED (Month, Day, Year)
5/26/96 | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
THOMAS FINUCAN, M.D. VA Maryland Health Care Systems, Perry Point, MD 21902 | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
MAY 28 1996 | | | | 32. REGISTRAR'S SIGNATURE
Widson-Randall | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

P.O. BOX 68760

DIVISION OF VITAL RECORDS

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

541

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 15617

| | | | | | | | | |
|---|--|--|---|--|--|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Mark Daniel Doran | | | | 2. Date of Death
Month Day Year
May 23, 1996 | | 3. Time of Death
2:00pm | |
| | 4a. Facility Name (If not institution, give street and number)
9244 Ft. Smallwood Road | | | | 4b. City, Town, or Location of Death
Pasadena | | 4c. County of Death
Anne Arundel | |
| Funeral
Director | 5. Social Security Number
214-66-0610 | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday)
38 Yrs. | | 8. Date of Birth (Month, Day, Year)
DEC 2, 1957 | |
| | 9. Birthplace (State or Foreign Country)
Maryland | | 10a. Usual Residence of Decedent
10e. State
Maryland | | 10b. County
Anne Arundel | | 10c. City, Town or Location
Pasadena | |
| To Be Completed by Funeral Director | 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 10e. Street and Number
9244 Ft. Smallwood Road | | 10f. Zip Code
21122 | | 10g. Citizen of What Country?
USA | |
| | 11. Marital Status
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: White | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (1-4 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Diesel Mechanic | | 16b. Kind of Business/Industry
Trucking Business | | | |
| | 17. Father's Name (First, Middle, Last)
Leo Edward Doran, Sr. | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Mildred Gertrude Wittman | | | |
| | 19a. Informant's Name/Relationship (Type, Print)
Katrina Lucille Hines/Friend | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
9244 Ft. Smallwood Rd. Pasadena, MD 21122 | | | |
| | 20a. Method of Disposition
<input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Metro Crematory, Inc. 5/24/96 | | 20c. Location - City or Town, State
Baltimore, MD | | | |
| | 21. Signature of Funeral Service Licensee
Dawn F. McDonald | | 22. Name and Address of Facility
Cremation Society of Maryland, Inc.
299 Frederick Rd. Baltimore, MD 21228 | | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
e. Respiratory Failure
Due to (or as a consequence of):
b. Metastatic Renal Carcinoma
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Approximate Interval Between Onset and Death
1 week
2 1/2 years | | | | | | | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | |
| | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | | | | | |
| 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | | | | |
| Medical Certification: To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify) | | | | | |
| | 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation
2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined
3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| | | | 28d. Describe how injury occurred | | 28e. Piece of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | |
| | 29a. Certifier
(Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | |
| | 29b. Signature and title of certifier
Elizabeth M. Jaffee, M.D. | | 29c. License number
MD 038653 | | 29d. Date signed (Month, Day, Year)
May 24, 1996 | | | |
| State Registrar | 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)
Elizabeth M. Jaffee, M.D., 7200 Park Heights Ave Baltimore, MD 21205 | | | | | | | |
| | 31. Date filed (Month, Day, Year)
MAY 28 1996 | | | | | | | |

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 15618

Certificate of Death

Reg. No.

| | | | | | | | | |
|---|--|---|--|--|---|---|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
William G. Dannenfelser | | | | 2. Date of Death
Month May Day 23 Year 1996 | | 3. Time of Death
11:58 pm | |
| | 4a. Facility Name (If not institution, give street and number)
Mercy Hospital | | | | 4b. City, Town, or Location of Death
Baltimore | | 4c. County of Death
n/a | |
| Funeral
Director | 5. Social Security Number
215-30-3662 | | 6. Sex
1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 7. Age (In yrs. last birthday)
62 Yrs. | | 8. Date of Birth (Month, Day, Year)
4/11/1934 | |
| | 9. Birthplace (State or Foreign Country)
Baltimore, Md. | | 10a. State
Md. | | 10b. County
n/a | | 10c. City, Town or Location
Baltimore | |
| 10d. Inside City Limits
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 10e. Street and Number
1421 S. Charles Street | | 10f. Zip Code
21230 | | 10g. Citizen of What Country?
USA | | |
| 11. Marital Status
1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: White | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 11th
College (1-4 or 5+) College | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Meat Cutter | | 16b. Kind of Business/Industry
Federal Hill Food Market | | | | |
| 17. Father's Name (First, Middle, Last)
William Dannenfelser | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Ruth Cooper | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
Ruth Peters Sister | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
205 S. Fagley St. Baltimore, Md. 21224 | | | | |
| 20a. Method of Disposition
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Dulaney Valley Cemetery | | 20c. Location - City or Town, State
5/28/96 Baltimore, Md. | | | | |
| 21. Signature of Funeral Service Licensee
<i>Joseph N. Zannino Jr.</i> | | | | 22. Name and Address of Facility
Joseph N. Zannino Jr.
263 S. Conkling St. Baltimore, Md. 21224 | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
Immediate Cause (Final disease or condition resulting in death)
a. <i>Cancer arrest 2° M-I. - acute</i>
Due to (or as a consequence of):
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
<i>N.I.D.D., HASCVD</i> | | | | | | | | |
| 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | | | | | | |
| 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | | |
| 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 28. Place of Death (Check only one)
Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation
2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined
3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day, Year)
<i>5/28/96</i> | | 28b. Time of injury
<i>M</i> | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | |
| | | 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
<i></i> | | 28d. Describe how injury occurred
<i></i> | | 28f. Location (Street and Number or Rural Route Number, City or Town, State)
<i></i> | | |
| 29a. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | |
| 29b. Signature and title of certifier
<i>Dr. Richard D. Meffezzoli</i> | | | | 29c. License number
<i>207132</i> | | 29d. Date signed (Month, Day, Year)
<i>5/28/96</i> | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Dr. Richard D. Meffezzoli 660 Kenilworth Dr. | | | | | | | | |
| 31. Date filed (Month, Day, Year)
MAY 28 1996 | | | | 32. Registrar's Signature
<i>Richard D. Meffezzoli</i> | | | | |

Baltimore, Maryland 21215-0020

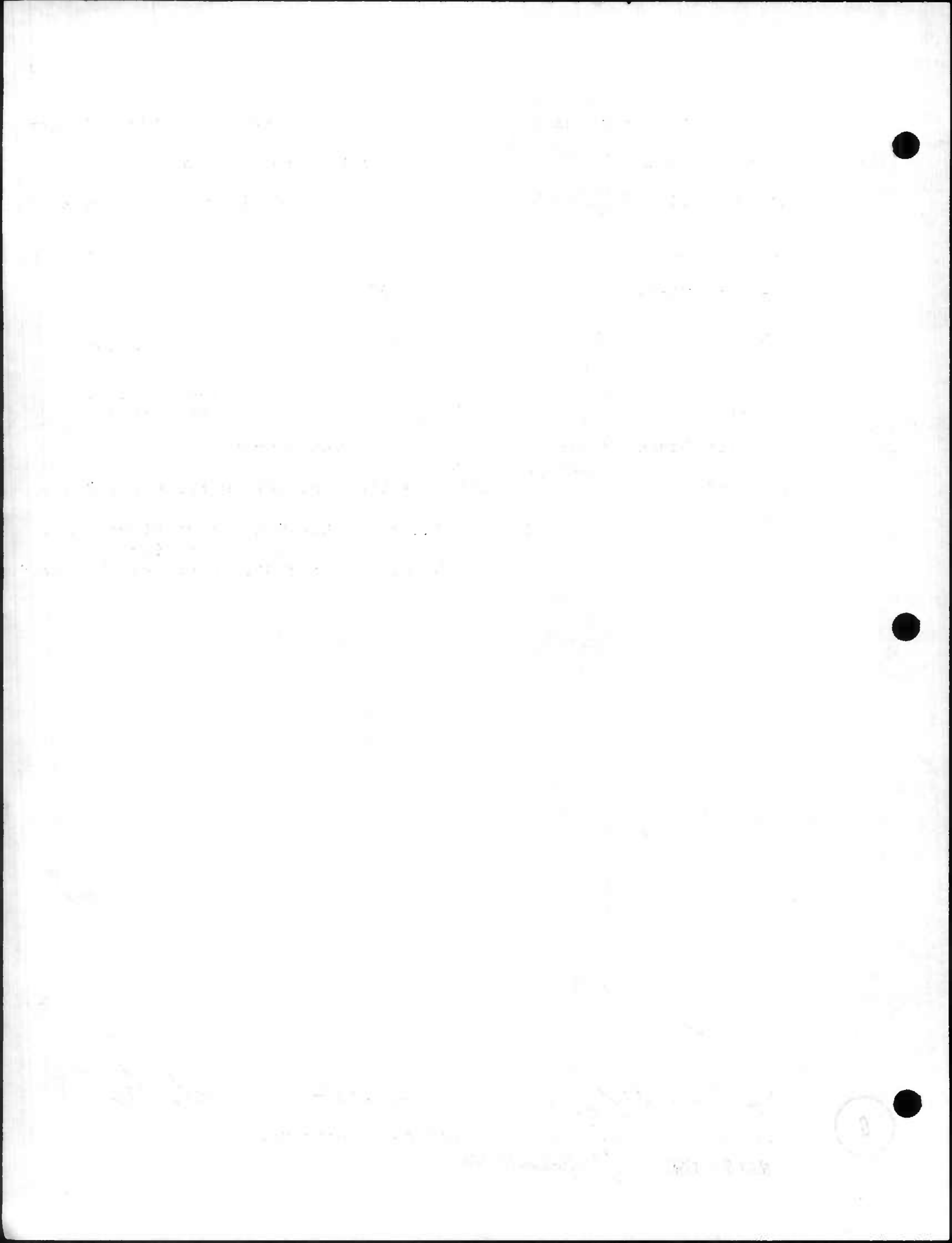
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 9054.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 15619

Certificate of Death

Reg. No.

| | | | | | | | | | | |
|--|--|--|--|--|---|--|---|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
HARRY | | | | 2. Date of Death
Month MAY Day 21 Year 1996 | | | | 3. Time of Death
7:30 AM | |
| | 4a. Facility Name (If not institution, give street and number)
110 NEEL AVE. | | | | 4b. City, Town, or Location of Death
REISTERSTOWN | | | | 4c. County of Death
BALTIMORE | |
| Funeral
Director | 5. Social Security Number
132-09-3891 | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday)
92 Yrs. | | If Under 1 Year
Months Days | | If Under 24 Hrs.
Hours Min. | |
| | 8. Date of Birth (Month, Day, Year)
MAY 15, 1904 | | 9. Birthplace (State or Foreign Country)
RUSSIA | | 10a. State
MARYLAND | | 10b. County
BALTIMORE | | 10c. City, Town or Location
REISTERSTOWN | |
| To Be Completed by Funeral Director | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 10e. Street and Number
110 NEEL AVE. | | 10f. Zip Code
21071 | | 10g. Citizen of What Country?
USA | | 11. Marital Status
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | |
| | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: WHITE | | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 2 College (1-4 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
PHARMACIST | |
| To Be Completed by Physician/Medical Examiner | 16b. Kind of Business/Industry
PHARMACY | | 17. Father's Name (First, Middle, Last)
HYMAN | | 18. Mother's Name (First, Middle, Maiden Surname)
CHANYA RUBANOWITZ | | 19a. Informant's Name/Relationship (Type, Print)
MR. CHARLES ESTRIN (SON) | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
39 RITTERS LANE OWINGWS MILLS, MD 21117 | |
| | 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input checked="" type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
BETH MOSES | | 20c. Location - City or Town, State
5-23-1996 PINELAWN, L.I., N.Y. | | 21. Signature of Funeral Service Licensee
<i>[Signature]</i> | | 22. Name and Address of Facility
SOL LEVINSON & BROS., INC.
8900 REISTERSTOWN RD., PIKESVILLE, MD 21208 | |
| Physician
/Medical
Examiner | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

a. Cardiopulmonary arrest
Due to (or as a consequence of):
b. Congestive heart failure
Due to (or as a consequence of):
c. Chronic renal failure
Due to (or as a consequence of):
d. Chronic bronchitis | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | Approximate Interval Between Onset and Death | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | |
| Medical Certification: To Be Completed by Physician/Medical Examiner | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | | 28e. Location (Street and Number or Rural Route Number, City or Town, State) | | 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | |
| | 29b. Signature and title of certifier
<i>[Signature]</i> | | 29c. License number
D 30339 | | 29d. Date signed (Month, Day, Year)
5/21/96 | | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
MILGA WISTER, MD 19 WALKER AVE, BALTIMORE, MD 21208 | | 31. Date filed (Month, Day, Year)
MAY 28 1996 | |
| 32. Registrar's Signature
<i>[Signature]</i> | | | | | | | | | | |

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 15620

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Marie Anna Eisel

2. Date of Death

Month Day Year
May 25, 1996

3. Time of Death

4:15 PM

4a. Facility Name (If not institution, give street and number)

Edenwald

4b. City, Town, or Location of Death

Towson

4c. County of Death

Baltimore

Funeral
Director

5. Social Security Number

220-34-5068

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

96

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
NOV 19, 1899

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Towson

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

800 Southerly Ave., Rm. D-107

10f. Zip Code

21286

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
6

College (1-4or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Home

17. Father's Name (First, Middle, Last)

Adolph Hirsch

18. Mother's Name (First, Middle, Maiden Surname)

Anna Bitter

19a. Informant's Name/Relationship (Type, Print)

James B. Eisel/Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2112 Oak Lodge Rd. Catonsville, MD 21228

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Metro Crematory, Inc. 5/26/96

Date

20c. Location - City or Town, State

Baltimore, MD

21. Signature of Funeral Service Licensee

George E. MacNabb

22. Name and Address of Facility

Cremation Society of Maryland, Inc.
299 Frederick Rd. Baltimore, MD 2122823a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Approximate
Interval Between
Onset and DeathImmediate Cause (Final
disease or condition
resulting in death)a. ORTHOASTATIC PULMONARY
Due to (or as a consequence of):

12 hours

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Lastb. ATRIAL FIBRILLATION
Due to (or as a consequence of):

104 hrs

c. OBSCURE PULMONARY EMBOLISM
Due to (or as a consequence of):

204 hrs

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?
1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☒ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
Investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide
4 ☐ Homicide28a. Date of Injury
(Month, Day, Year)28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

John Shayers

29c. License number

D27838

29d. Date signed (Month, Day, Year)

5/26/96

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

John Shayers, 800 Southerly Rd, Towson, MD

31. Date filed (Month, Day, Year)

MAY 28 1996

32. Registrar's Signature

John Shayers

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
ExaminerDivision of Vital Records, P.O. Box 68760,
To the Hospital of Attending Physician: The law requires that the death certificate be executed
within 72 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit


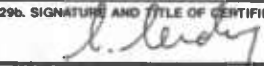
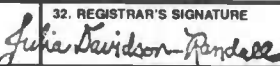
Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

96 15621

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | |
|--|--|--|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
MORRIS FEINTUCH | | 2. DATE OF DEATH
MONTH DAY YEAR
MAY 23, 1996 | | 3. TIME OF DEATH
2:40pm | |
| 4. SOCIAL SECURITY NUMBER
212-05-9281 | | 5. SEX
1 <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
90 YRS. | |
| 7. DATE OF BIRTH
(Month, Day, Year)
MAR. 14, 1906 | | 8. BIRTHPLACE (State or Foreign Country)
POLAND | | | |
| 9a. FACILITY NAME (If not institution, give street and number)
PIKESVILLE NURSING HOME | | 9b. CITY, TOWN OR LOCATION OF DEATH
PIKESVILLE | | 9c. COUNTY OF DEATH
BALTIMORE | |
| RESIDENCE OF DECEDENT | | | | | |
| 10a. STATE
MARYLAND | | 10b. COUNTY
N/A | | 10c. CITY, TOWN OR LOCATION
BALTIMORE | |
| 10d. INSIDE CITY LIMITS?
1 <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | | | | |
| 10e. STREET AND NUMBER
6965 GLENHEIGHTS RD. | | 10f. ZIP CODE
21215 | | 10g. CITIZEN OF WHAT COUNTRY?
USA | |
| 11. MARITAL STATUS
2 <input checked="" type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | |
| 14. RACE — American Indian, Black, White, etc.
Specify:
WHITE | | | | | |
| 15. DECEDENT'S EDUCATION
(Specify only highest grade completed)
6 Elementary/Secondary (0-12) College (1-4 or 5+) | | 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.)
SALESMAN | | 16b. KIND OF BUSINESS/INDUSTRY
FURNITURE & CLOTHING | |
| 17. FATHER'S NAME (First, Middle, Last)
DAVID FEINTUCH | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
FREDA HERSHMAN | | | |
| 19a. INFORMANT'S NAME (Type/Print)
MR. KARL FEINTUCH (SON) | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
2851 COUNTRY LANE ELLICOTT CITY, MD 21042 | | | |
| 20a. METHOD OF DISPOSITION
1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of place, date, and place of disposition)
ANSHE NEISEN | | 20c. LOCATION — City or Town, State
5-26-1996- ROSEDALE, MD | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
 | | 22. NAME AND ADDRESS OF FACILITY
SOL LEVINSON & BROS., INC.
8900 REISTERSTOWN ROAD PIKESVILLE, MD 21208 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → CEREBROVASCULAR ACCIDENT | | | | | |
| Due to (or as a consequence of): | | | | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | |
| Due to (or as a consequence of): GENERALIZED ARTERIOSCLEROSIS | | | | | |
| Due to (or as a consequence of): | | | | | |
| Due to (or as a consequence of): | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
- CORONARY ARTERY DISEASE
- DIABETES | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> OOA
OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | |
| 27. MANNER OF DEATH
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation
2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined
3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M | |
| 28c. INJURY AT WORK?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | | | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one)
1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
 M.D. | | 29c. LICENSE NUMBER
D-22609 | | 29d. DATE SIGNED (Month, Day, Year)
5-23-96 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
RUBEN REIDER M.D. 7445 FURNACE BRANCH Rd. Glen Burnie MD 21060 | | | | | |
| 31. DATE FILED (Month, Day, Year)
MAY 28 1996 | | 32. REGISTRAR'S SIGNATURE
 | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 15622

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

JOHN RIFE FOX

2. Date of Death

Month Day Year
MAY 24 1996

3. Time of Death

2:10 PM

Funeral
Director

4a. Facility Name (If not institution, give street and number)

SAINT JOSEPH MEDICAL CENTER

4b. City, Town, or Location of Death

TOWSON, MD

4c. County of Death

BALTIMORE

5. Social Security Number

216-05-2646

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

85 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

Mar. 25, 1911

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

BALTIMORE

10c. City, Town or Location

PARKTON

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

1419 Armacost Rd.

10f. Zip Code

21120

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

12

3

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Right of Way Agent

16b. Kind of Business/Industry

Md Highway Administration

17. Father's Name (First, Middle, Last)

John Rife Fox, Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Carrie Grace Unglaub

19a. Informant's Name/Relationship (Type, Print)

Frances Katherine Swim

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

520 Lemmon Rd., Westminster, MD 21157

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Belair Memorial Gardens

Date

29

20c. Location - City or Town, State

Belair, MD

21. Signature of Funeral Service Licensee

Bryan W. Clary

22. Name and Address of Facility

Lemmon Funeral Home of Dulaney Valley, Inc.
10 W. Padonia Rd., Timonium, MD 21093

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

a. RESPIRATORY FAILURE SECONDARY TO

Due to (or as a consequence of):

7 DAYS

b. CARDIOPULMONARY ARREST

Due to (or as a consequence of):

c. HYPERTENSIVE ARTERIOSCLEROTIC

Due to (or as a consequence of):

YEARS

d. CARDIOVASCULAR DISEASE

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

2 ☒ Inpatient3 ☐ ER/Outpatient4 ☐ DOA

Other:

26. Place of Death (Check only one)

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Natividad D. de Leon, M.D.

29c. License number

D19508

29d. Date signed (Month, Day, Year)

24th, May, 1996

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

NATIVIDAD D. DELEON M.D. SAINT JOSEPH MEDICAL CENTER, TOWSON, MD 21204

State
Registrar

31. Date filed (Month, Day, Year)

MAY 28 1996

32. Registrar's Signature

Julia Davidson-Ross

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

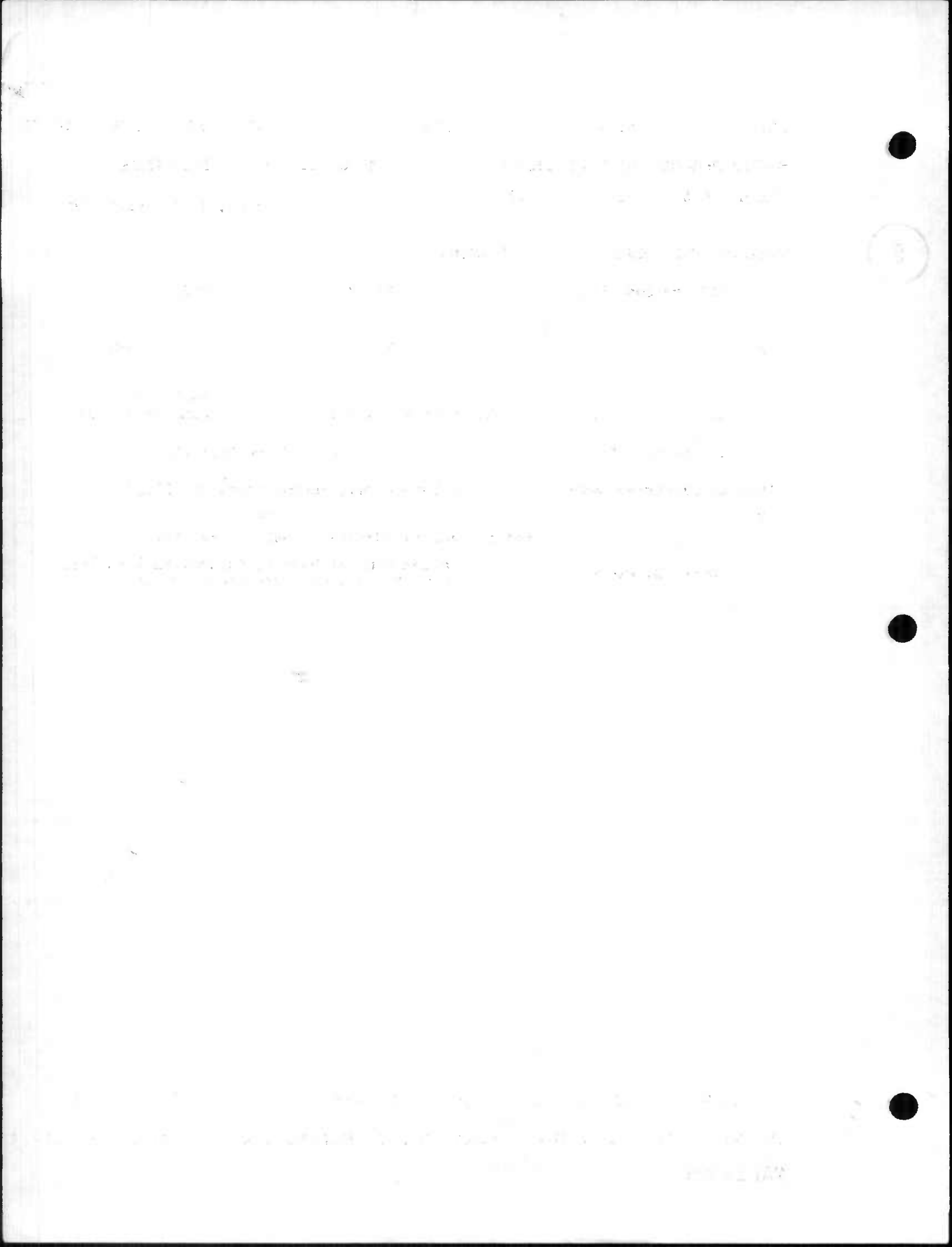
permit. Pages 1 and 2 should be filed within 72 hours after death with the
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 23a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



96 15623

DMMH 16 Rev 6/95

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If Item 27 is marked other than "natural", or Items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

**Physician
/Medical
Examiner**

At the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

100-100000

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 15624

Certificate of Death

Reg. No.

| | | | | | | | | | |
|---|---|---|---|--|--|---|---|---|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Janice May Roque-Garza | | | | 2. Date of Death
Month Day Year
May 25, 1996 | | 3. Time of Death
2:35 AM | | |
| | 4a. Facility Name (If not institution, give street and number)
Spa Creek Genesis Elder Care | | | | 4b. City, Town, or Location of Death
Annapolis | | 4c. County of Death
Anne Arundel | | |
| Funeral
Director | 5. Social Security Number
047-40-6950 | | 6. Sex
1 <input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)
44 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth (Month, Day, Year)
May 8, 1952 | 9. Birthplace (State or Foreign Country)
Connecticut | |
| | Usual Residence of Decedent | | | | | | | | |
| To Be Completed by Funeral Director | 10a. State
Maryland | | 10b. County
Anne Arundel | | 10c. City, Town or Location
Annapolis | | | 10d. Inside City Limits
1 <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| | 10e. Street and Number
1217 Green Holly Drive | | | | 10f. Zip Code
21401 | | 10g. Citizen of What Country?
USA | | |
| | 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: White | | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (1-4 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Secretary | | | 16b. Kind of Business/Industry
Temporary Office Staff | | | |
| | 17. Father's Name (First, Middle, Last)
David Orville Curtis | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Janice May Surdan | | | | |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print)
Bianca C. Coffin/Daughter | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1217 Green Holly Dr. Annapolis, MD 21401 | | | | |
| | 20a. Method of Disposition
1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Metro Crematory, Inc. 5/25/96 | | 20c. Location - City or Town, State
Baltimore, MD | | | | |
| | 21. Signature of Funeral Service Licensee

George E. MacNabb | | | | 22. Name and Address of Facility
Cremation Society of Maryland, Inc.
299 Frederick Rd. Baltimore, MD 21228 | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. Adenocarcinoma of Lung Bron
Due to (or as a consequence of):
b. site unknown
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | | |
| | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 24e. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation
2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined
3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | |
| | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier

DR COLE | | 29c. License number
008118 | | 29d. Date signed (Month, Day, Year)
5/25/96 | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
SP WATKINS 900 BOSTON RD ANNAPOLIS MD 21401 | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
MAY 28 1996 | | 32. Registrar's Signature
 | | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

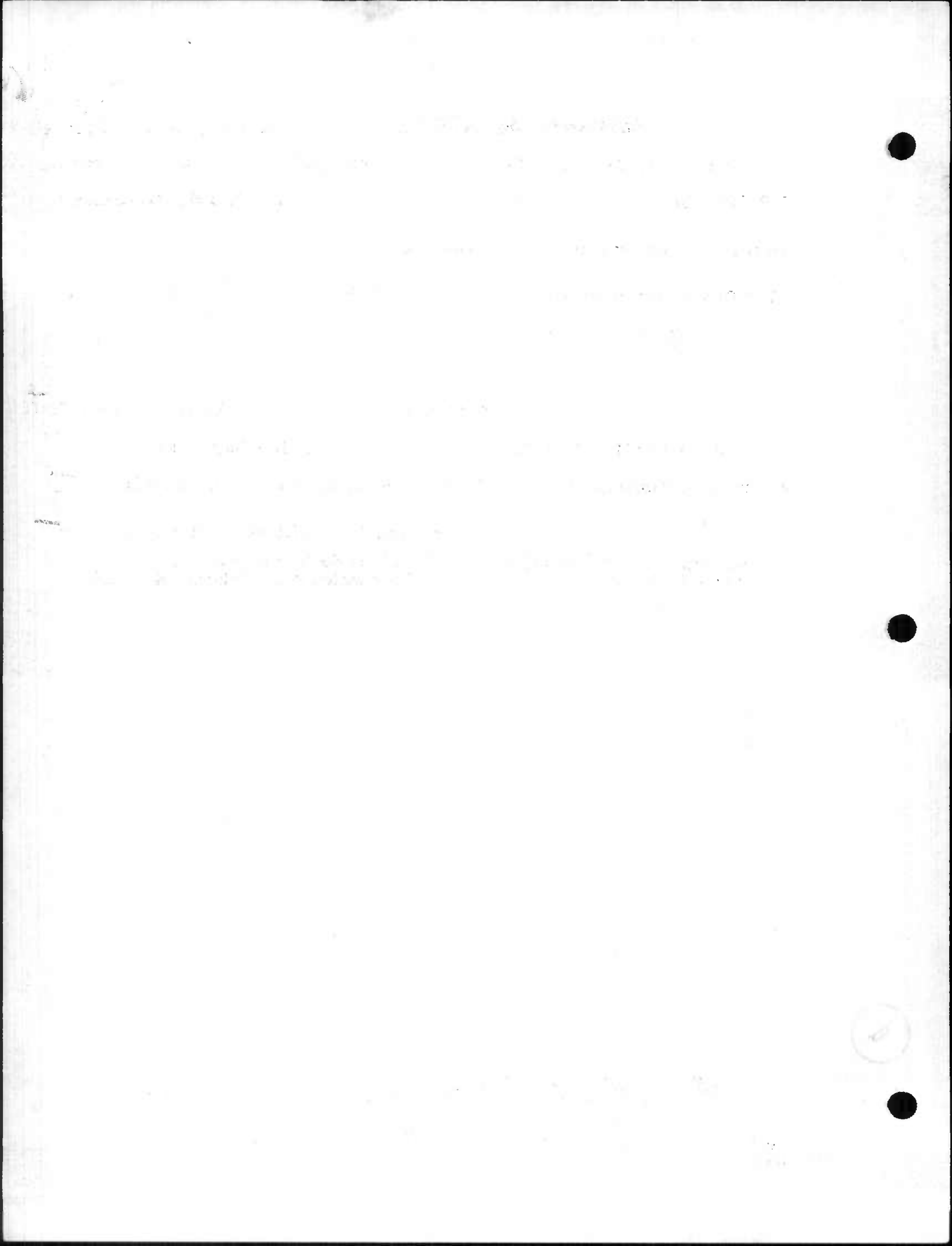
Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 48 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner



96 15625

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
Mary Gross | | | | 2. DATE OF DEATH
MONTH DAY YEAR
May 24 1996 | | 3. TIME OF DEATH
7:35 AM | |
| 4. SOCIAL SECURITY NUMBER
212-22-4712 | | 5. SEX
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
81 YRS. | | 7. DATE OF BIRTH (Month, Day, Year)
Jan. 19, 1915 | |
| 8a. FACILITY NAME (If not institution, give street and number)
Frederick Villa Nursing Home | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
Catonsville | | 9c. COUNTY OF DEATH
Baltimore | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE
Maryland | | 10b. COUNTY
Baltimore | | 10c. CITY, TOWN OR LOCATION
Catonsville | | 10d. INSIDE CITY LIMITS?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 10e. STREET AND NUMBER
711 Academy Road | | | | 10f. ZIP CODE
21228 | | 10g. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 11. MARITAL STATUS
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify: White | |
| 15. DECEDENT'S EDUCATION
(Specify only highest grade completed)
Elementary/Secondary (0-12) 7 | | 15a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.)
Homemaker | | 16b. KIND OF BUSINESS/INDUSTRY
Own Home | | | |
| 17. FATHER'S NAME (First, Middle, Last)
Allen Dean | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Victoria Griffth | | | |
| 19a. INFORMANT'S NAME (Type/Print)
Joseph Gross (Son) | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1830 Frederick Road Catonsville, Maryland 21228 | | | |
| 20a. METHOD OF DISPOSITION
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
Loudon Park Cemetery May 28, 1996 | | 20c. LOCATION — City or Town, State
Baltimore, Maryland | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
<i>[Signature]</i> | | | | 22. NAME AND ADDRESS OF FACILITY
Witzke Funeral Homes Inc.
1630 Edmondson Avenue Catonsville, Maryland | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | | a. Acute respiratory failure
DUE TO (OR AS A CONSEQUENCE OF): | | | | | |
| | | b. Acute bronchitis
DUE TO (OR AS A CONSEQUENCE OF): | | | | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | c. _____
DUE TO (OR AS A CONSEQUENCE OF): | | | | | |
| | | d. _____
DUE TO (OR AS A CONSEQUENCE OF): | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Senile dementia | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA
OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH
1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation
2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined
3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M | | 28c. INJURY AT WORK?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28d. DESCRIBE HOW INJURY OCCURRED | | | |
| 29a. CERTIFIER (Check only one)
1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. SIGNATURE AND TITLE OF CERTIFIER
<i>[Signature]</i> MD | | 29c. LICENSE NUMBER
028236 | | 29d. DATE SIGNED (Month, Day, Year)
May 24, 1996 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
Dorian S St Martin 544 Old Frederick Rd Baltimore 21228 | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
MAY 28 1996 | | 32. REGISTRAR'S SIGNATURE
<i>[Signature]</i> | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

ITEMS: 1. & 15, PER F.H. FILM

G-7355/28/96 t.t

State of Maryland / Department of Health and Mental Hygiene

96 15626

ITEMS#2&5 film g736 6/3/96ag perFH

Certificate of Death

Reg. No.

| | | | | | | | | |
|--|---|--|---|--|--|--|---|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
HIGGINS MAYFORD MAYFORD HIGGINS | | | | 2. Date of Death
Month MAY Day 23 Year 1996 | | 3. Time of Death
12:01 AM | |
| | 4a. Facility Name (If not institution, give street and number)
Howard Co Gen Hosp. | | | | 4b. City, Town, or Location of Death
Columbia | | 4c. County of Death
Howard Co. | |
| Funeral
Director | 5. Social Security Number
246-18-7840 | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday)
74 Yrs. | | 8. Date of Birth (Month, Day, Year)
3-20-1922 | |
| | 9. Birthplace (State or Foreign Country)
N. Wilkesboro, NC | | 10a. State
MD. | | 10b. County
Howard Co. | | 10c. City, Town or Location
Jessups | |
| To Be Completed by Funeral Director | 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 10e. Street and Number
7310 Wye Ave. | | 10f. Zip Code
20794 | | 10g. Citizen of What Country?
U.S.A. | |
| | 11. Marital Status
<input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: White | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 11TH College (1-4or 5+) 0 | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Supervisor | | 16b. Kind of Business/Industry
Clifton T. Perkins Hospital | | | |
| | 17. Father's Name (First, Middle, Last)
Zach Higgins | | | | 18. Mother's Name (First, Middle, Maiden Surname)
W/A | | | |
| | 19a. Informant's Name (Relationship, Name, Print)
Mrs. Peggy Broughton | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
7310 Wye Ave. Jessups, Maryland 20794 | | | |
| | 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Meadowridge Memorial Park 730 Elkridge, Md. | | 20c. Location - City or Town, State | | | |
| | 21. Signature of Funeral Service Licensee
Joseph F. Russ | | | | 22. Name and Address of Facility
Joseph F. Russ Funeral Home, 2552 W. North Ave. Baltimore Md. 21216 | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
Septic Shock
Due to (or as a consequence of):
Gm (-) sepsis
Respiratory failure
Due to (or as a consequence of):
Congestive heart failure | | | | | | | |
| | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | | | |
| | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | |
| Medical Certification: To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| | 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accidental <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| | 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28d. Describe how injury occurred | | | | | |
| | 28e. Location (Street and Number or Rural Route Number, City or Town, State) | | 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | |
| | 29b. Signature and title of certifier
[Signature] MD | | 29c. License number
D42019 | | 29d. Date signed (Month, Day, Year)
5/23/96 | | | |
| State Registrar | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
IRAN CHOWDHURY 7350 VAN DUSEN RD LAUREL MD 20797 | | | | 31. Date filed (Month, Day, Year)
MAY 28 1996 | | | |
| | 32. Registrar's Signature
[Signature] | | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28c-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 15627

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

NETTIE HURWITZ

2. Date of Death

Month Day Year
MAY 24, 1996

3. Time of Death

11:45 PM

4a. Facility Name (If not institution, give street and number)

NORTHWEST HOSPITAL CENTER

4b. City, Town, or Location of Death

RANDALLSTOWN

4c. County of Death

BALTIMORE

Funeral
Director

5. Social Security Number

214-10-0176

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

86 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
SEPT. 28, 1909

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

MD

10b. County

BALTIMORE

10c. City, Town or Location

REISTERSTOWN

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

12020 REISTERSTOWN RD.

10f. Zip Code

21136

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

12

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

SALES

16b. Kind of Business/Industry

RETAIL

17. Father's Name (First, Middle, Last)

HARRY ZASLOVSKY

18. Mother's Name (First, Middle, Maiden Surname)

MINNIE KARCHER

19a. Informant's Name/Relationship (Type, Print)

MRS. DEBRA KIRK (DAUGHTER)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

12 LAMPLIGHTER CT; BALTIMORE, MD 21208

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

BALTIMORE HEBREW

Date

MAY 27, 1996

20c. Location - City or Town, State

REISTERSTOWN, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

SOL LEVINSON & BROS., INC.

8900 REISTERSTOWN ROAD PIKESVILLE, MD 21208

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. SEPTIC

Due to (or as a consequence of):

b. UTI

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

10 days

5 days

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

CVA

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation2 ☐ Accident3 ☐ Suicide4 ☐ Homicide6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of Certifier

29c. License number

D44505

29d. Date signed (Month, Day, Year)

MAY 24, 1996

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

A.J. IMPERIA, JR. - NW & E

State
Registrar

31. Date filed (Month, Day, Year)

MAY 28 1996

32. Registrar's Signature

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death within Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

... ..
... ..
... ..
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 15628

Certificate of Death

Reg. No.

| | | | | | | | | | | | | | | | |
|--|--|---|--|---|---|---|---|--|---|---|---------------------------------------|--|-----------------------------------|----|----|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
ANNA M. HAMLIN | | | | 2. Date of Death
Month MAY Day 25 Year 1996 | | | | 3. Time of Death
6:45 A.M. | | | | | | |
| | 4a. Facility Name (If not institution, give street and number)
NORTH ARUNDEL HOSPITAL 301 Hospital Drive Glen Burnie | | | | 4b. City, Town, or Location of Death
ANNE ARUNDEL | | | | 4c. County of Death
MARYLAND | | | | | | |
| Funeral
Director | 5. Social Security Number
216-12-7311 | | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday)
72 Yrs. | | 8. Date of Birth (Month, Day, Year)
10-2-23 | | 9. Birthplace (State or Foreign Country)
MARYLAND | | | | | | |
| | Usual Residence of Decedent | | | | | | | | | | | | | | |
| 10a. State
MARYLAND | | 10b. County
A. A. CO. | | 10c. City, Town or Location
GLEN BURNIE | | | | 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | |
| 10e. Street and Number
526 NOLWOOD COURT | | | | 10f. Zip Code
21061 | | | | 10g. Citizen of What Country?
USA | | | | | | | |
| 11. Marital Status
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | | 14. Race - American Indian, Black, White, etc.
Specify: WHITE | | | | | | | |
| 15. Decedent's Education (Specify only highest grade completed)
8 YEARS | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
HOMEMAKER | | | | 16b. Kind of Business/Industry
OWN HOME | | | | | | | |
| 17. Father's Name (First, Middle, Last)
STEVE STROBEL | | | | 18. Mother's Name (First, Middle, Maiden Surname)
JOSEPHINE SHERRICK | | | | | | | | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
MR. THOMAS HAMLIN | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
526 NOLWOOD COURT GLEN BURNIE, MD. 21061 | | | | | | | | | | | |
| 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
HOLY ROSARY CEMETERY | | Date
5-29-96 | | 20c. Location - City or Town, State
BALTO. CO. MD. | | | | | | | | | |
| 21. Signature of Funeral Service Licensee
Charles R. Kaczorowski | | | | 22. Name and Address of Facility
KACZOROWSKI FUNERAL HOME
1201 DUNDALK AVE. BALTO. MD. 21222 | | | | | | | | | | | |
| 23a. Part I. Enter the disease, or complications, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | | | | | | | | | |
| <table border="1"> <tr> <td rowspan="4">Immediate Cause (Final disease or condition resulting in death)</td> <td>a. ACUTE MYOCARDIAL INFARCTION</td> <td rowspan="4">Approximate Interval Between Onset and Death
1 day</td> </tr> <tr> <td>b. ISCHEMIC CARDIOMYOPATHY</td> </tr> <tr> <td>c. </td> </tr> <tr> <td>d. </td> </tr> </table> | | | | | | | | | | Immediate Cause (Final disease or condition resulting in death) | a. ACUTE MYOCARDIAL INFARCTION | Approximate Interval Between Onset and Death
1 day | b. ISCHEMIC CARDIOMYOPATHY | c. | d. |
| Immediate Cause (Final disease or condition resulting in death) | a. ACUTE MYOCARDIAL INFARCTION | Approximate Interval Between Onset and Death
1 day | | | | | | | | | | | | | |
| | b. ISCHEMIC CARDIOMYOPATHY | | | | | | | | | | | | | | |
| | c. | | | | | | | | | | | | | | |
| | d. | | | | | | | | | | | | | | |
| 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | | | | | | | | | | | |
| 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | | | | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
CONGESTIVE HEART FAILURE | | | | | | | | | | | | | | | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | | | | | | | | |
| 26. Place of Death (Check only one)
Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | | | | | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation
<input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined
<input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | | | | | | | |
| 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | | | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | | | | | | |
| 29b. Signature and title of certifier
MD | | | | 29c. License number
D43477 | | | | 29d. Date signed (Month, Day, Year)
MAY 25th 1996 | | | | | | | |
| 30. Name and address of person who completed cause of death (item 23e) (Type, Print)
Ayoku Dketunji, 301 Hospital Dr. Glen Burnie, MD | | | | | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
MAY 28 1996 | | | | | | | | | | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 15629

Certificate of Death

Reg. No.

| | | | | | | | | |
|---|---|--|---|---|---|--|---|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
JOHN D. HILL | | | | 2. Date of Death
Month: May Day: 22, Year: 1996 | | 3. Time of Death
8:00 am | |
| | 4a. Facility Name (If not institution, give street and number)
123 W. 29th Street Apt. 6D | | | | 4b. City, Town, or Location of Death
Baltimore | | 4c. County of Death
N/A | |
| Funeral
Director | 5. Social Security Number
241-12-6870 | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday)
75 Yrs. | | 8. Date of Birth (Month, Day, Year)
APR. 6, 1921 | |
| | 9. Birthplace (State or Foreign Country)
N. Carolina | | 10a. State
Maryland | | 10b. County
N/A | | 10c. City, Town or Location
Baltimore | |
| To Be Completed by Funeral Director | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 10e. Street and Number
123 W. 29th Street Apt. 6D | | 10f. Zip Code
21218 | | 10g. Citizen of What Country?
United States | |
| | 11. Marital Status
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
If Yes, Give Year or Dates: Army Unk. | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: Black | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12): 8th College (1-4 or 5+): - | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Burner | | 16b. Kind of Business/Industry
Sparrows Point | | | |
| | 17. Father's Name (First, Middle, Last)
Charlie Hill | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Viola | | | |
| | 19a. Informant's Name/Relationship (Type, Print)
Ida Phillips | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
2325 Barclay Street, Baltimore, MD 21218 | | | |
| | 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
CHAPEL HILL CEMETERY | | 20c. Location - City or Town, State
CHAPEL HILL, NC | | 20d. Date
5-25 | |
| | 21. Signature of Funeral Service Licensee
<i>[Signature]</i> | | | | 22. Name and Address of Facility
March Funeral Home
1101 E. North Avenue, Baltimore, MD 21202 | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. <i>Hypertensive Atherosclerotic Cardiac Disease >10 yrs</i>
Due to (or as a consequence of):
b. _____ Due to (or as a consequence of):
c. _____ Due to (or as a consequence of):
d. _____
Sequitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | |
| | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | | | |
| | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | |
| Medical Certification: To Be Completed by Physician/Medical Examiner | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | |
| | 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | |
| | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | |
| | 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 28d. Describe how Injury occurred | | | | | | | | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | | | | | |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | |
| 29b. Signature and title of certifier
<i>Sharon Allison MD</i> | | | | 29c. License number
AT 2438946 | | 29d. Date signed (Month, Day, Year)
5/24/96 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Dr. Sharon Allison, M.D., Union Memorial Hosp | | | | | | | | |
| 31. Date filed (Month, Day, Year)
MAY 28 1996 | | | | 32. Registrar's Signature
<i>John American Randall</i> | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

5 + 1

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 15630

Certificate of Death

Reg. No.

| | | | | | | | | |
|--|--|---|--|--|---|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
<u>ROSE HORNBERGER</u> | | | | 2. Date of Death
Month <u>5</u> Day <u>24</u> Year <u>96</u> | | 3. Time of Death
<u>7¹⁰ PM</u> | |
| | 4a. Facility Name (If not institution, give street and number)
<u>HOPKINS BAY VIEW HOSPITAL</u> | | | | 4b. City, Town, or Location of Death
<u>BALTIMORE</u> | | 4c. County of Death
<u>N/A</u> | |
| Funeral
Director | 5. Social Security Number
<u>215-09-6187</u> | | 6. Sex
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)
<u>86</u> Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth (Month, Day, Year)
<u>6-17-09</u> | 9. Birthplace (State or Foreign Country)
<u>MARYLAND</u> |
| | Usual Residence of Decedent | | | | | | | |
| 10a. State
<u>MARYLAND</u> | | 10b. County
<u>BALTIMORE</u> | | 10c. City, Town or Location
<u>EDGEMERE</u> | | | 10d. Inside City Limits
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | |
| 10e. Street and Number
<u>2825 LODGE FARM ROAD</u> | | 10f. Zip Code
<u>21219</u> | | 10g. Citizen of What Country?
<u>USA</u> | | | | |
| 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever In U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: <u>WHITE</u> | | |
| 15. Decedent's Education (Specify only highest grade completed)
<u>4 YEARS</u> | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
<u>HOMEMAKER</u> | | 16b. Kind of Business/Industry
<u>OWN HOME</u> | | | | |
| 17. Father's Name (First, Middle, Last)
<u>FRANK KORDEK</u> | | | | 18. Mother's Name (First, Middle, Maiden Summa)
<u>MARIE (UNKNOWN)</u> | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
<u>MR. EDWARD BIVONS</u> | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
<u>837 STAFFORDSHIRE RD. COCKEYSVILLE, MD. 21030</u> | | | | |
| 20a. Method of Disposition
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
<u>1 ST UNITED CHURCH CEM.</u> | | Data
<u>5-28-96</u> | | 20c. Location - City or Town, State
<u>BALTO. MD. 21224</u> | | |
| 21. Signature of Funeral Service Licensee
<u>Charles R. Kaczorowski</u> | | | | 22. Name and Address of Facility
<u>KACZOROWSKI FUNERAL HOME</u>
<u>1201 DUNDALK AVE. BALTO. MD. 21222</u> | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | | Approximate Interval Between Onset and Death |
| Immediate Cause (Final disease or condition resulting in death)
a. <u>ACUTE SUBENDOCARDIAL MYOCARDIAL INFARCTION</u> <u>24 hours</u>
Due to (or as a consequence of):
b. <u>CORONARY ARTERY DISEASE</u>
Due to (or as a consequence of):
c. <u>HYPERTENSION</u>
Due to (or as a consequence of):
d. <u>DIABETES</u> | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
<u>GASTROINTESTINAL BLEEDING</u> | | | | | | | | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown |
| 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |
| 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accidental 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide
5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred |
| 29a. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier
<u>James Farrell - MEDICAL PHYSICIAN</u> | | 29c. License number
<u>M6359</u> | | 29d. Date signed (Month, Day, Year)
<u>05/24/1996</u> | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
<u>DR JAMES FARRELL, MD, BAYVIEW CCU, BALTIMORE, MD</u> | | | | | | | | |
| 31. Date filed (Month, Day, Year)
<u>MAY 28 1996</u> | | 32. Registrar's Signature
<u>John Davidson-Randall</u> | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 24a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 15631

Certificate of Death

Reg. No.

| | | | | | | | | | | |
|--|---|---|---|--|---|---|--|--|---|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
JOAN C. HILL | | | | | 2. Date of Death
Month May Day 23 Year 1996 | | 3. Time of Death
8:00 am | | |
| | 4a. Facility Name (If not institution, give street and number)
1631 W. North Avenue | | | | | 4b. City, Town, or Location of Death
Baltimore | | 4c. County of Death
N/A | | |
| Funeral
Director | 5. Social Security Number
212-70-6599 | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday)
35 Yrs. | | 8. Date of Birth (Month, Day, Year)
01/08/58 | | 9. Birthplace (State or Foreign Country)
MD | |
| | Usual Residence of Decedent | | | | | | | | | |
| 10a. State
MD | | 10b. County
N/A | | 10c. City, Town or Location
Baltimore | | | | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | |
| 10e. Street and Number
1631 W. North Avenue | | | | 10f. Zip Code
21217 | | 10g. Citizen of What Country?
USA | | | | |
| 11. Marital Status
<input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever In U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc.
Specify: Black | | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (1-4 or 5+) - 0 - | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Sexton | | | 16b. Kind of Business/Industry
Hospital | | | |
| 17. Father's Name (First, Middle, Last)
John C. Hill | | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Barbara Hill | | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
Barbara Hill | | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1631 W. North Avenue, Balto., MD 21217 | | | | | |
| 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
New Cathedral Cem. | | Date
5/30 | | 20c. Location - City or Town, State
Balto., MD | | | |
| 21. Signature of Funeral Service Licensee
Vernon R. Bailey | | | | | 22. Name and Address of Facility
Vernon R. Bailey
4216 Ridgewood Avenue | | | | | |
| 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

a. RESPIRATORY FAILURE
b. AIDS
c. HIV INFECTION
d.

Approximate Interval Between Onset and Death

3 yrs
8 yrs | | | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | |
| | | | | | | | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | |
| | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. Manner of Death
<input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation
<input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined
<input type="checkbox"/> Suicida <input type="checkbox"/> Homicide | | | 28a. Date of Injury (Month, Day, Year)
N/A | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
N/A | | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | | | |
| 29b. Signature and title of certifier
DOLPH A. TRUCKMAN | | | | | 29c. License number
D28781 | | 29d. Date signed (Month, Day, Year)
5-23-96 | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
DOLPH A. TRUCKMAN MD LIB. MED CTR BALTO 21215 | | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
MAY 28 1996 | | | | | 32. Registrar's Signature
Julia Davidson-Randall | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 96 15632

Certificate of Death

Reg. No.

| | | | | | | | | | | | | | | |
|---|--|---|---|--|--|--|--|--|---|--|---|---|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
<u>CHARLES HORTON</u> | | | | 2. Date of Death
Month <u>MAY</u> Day <u>24</u> Year <u>96</u> | | 3. Time of Death
<u>7 AM</u> | | | | | | | |
| | 4e. Facility Name (If not institution, give street and number)
<u>SINAI HOSPITAL</u> | | | | 4b. City, Town, or Location of Death
<u>BALTIMORE</u> | | 4c. County of Death
<u>N/A</u> | | | | | | | |
| Funeral
Director | 5. Social Security Number
<u>452-03-2403</u> | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday)
<u>84</u> Yrs. | | 8. Date of Birth (Month, Day, Year)
<u>4/28/12</u> | | | | | | | |
| | Usual Residence of Decedent | | 9. Birthplace (State or Foreign Country)
<u>Texas</u> | | 10. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | | |
| To Be Completed by Funeral Director | 10a. State
<u>Md.</u> | | 10b. County
<u>Baltimore</u> | | 10c. City, Town or Location
<u>Catonsville</u> | | 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | |
| | 10e. Street and Number
<u>715 Maiden Choice Lane HV 316</u> | | | | 10f. Zip Code
<u>21228</u> | | 10g. Citizen of What Country?
<u>U.S.A.</u> | | | | | | | |
| | 11. Marital Status
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: <u>White</u> | | | | | | | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) <u>2</u> College (1-4 or 5+) <u>2</u> | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
<u>Method Analyst</u> | | 16b. Kind of Business/Industry
<u>Federal Government</u> | | | | | | | | | |
| | 17. Father's Name (First, Middle, Last)
<u>David Horton</u> | | | | 18. Mother's Name (First, Middle, Maiden Surname)
<u>Inez Dorn</u> | | | | | | | | | |
| | 19e. Informant's Name/Relationship (Type, Print)
<u>Gwendolyn M. Horton (Spouse)</u> | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
<u>715 Maiden Choice Lane Catonsville, Maryland 21228</u> | | | | | | | | | |
| | 20e. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
<u>Lakeview Cemetery May 28, 1996</u> | | 20c. Location - City or Town, State
<u>Sykesville, Maryland</u> | | | | | | | | | |
| | 21. Signature of Funeral Service Licensee
<u>[Signature]</u> | | | | 22. Name and Address of Facility
<u>Witzke Funeral Homes, Inc. 21228</u>
<u>1630 Edmondson Avenue Catonsville, Maryland</u> | | | | | | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | | | | | | | |
| | <table border="0"> <tr> <td rowspan="4"> Immediate Cause (Final disease or condition resulting in death)

 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last </td> <td>a. <u>RIGHT VENTRICULAR MYOCARDIAL INFARCT</u></td> <td rowspan="4"> Due to (or as a consequence of):

 b. <u>CORONARY ARTERY DISEASE</u>

 c.

 d. </td> <td rowspan="4"> Approximate Interval Between Onset and Death

 <u>8 HRS.</u> </td> </tr> <tr><td></td></tr> <tr><td></td></tr> <tr><td></td></tr> </table> | | | | | | | | Immediate Cause (Final disease or condition resulting in death)

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | a. <u>RIGHT VENTRICULAR MYOCARDIAL INFARCT</u> | Due to (or as a consequence of):

b. <u>CORONARY ARTERY DISEASE</u>

c.

d. | Approximate Interval Between Onset and Death

<u>8 HRS.</u> | | |
| Immediate Cause (Final disease or condition resulting in death)

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | a. <u>RIGHT VENTRICULAR MYOCARDIAL INFARCT</u> | Due to (or as a consequence of):

b. <u>CORONARY ARTERY DISEASE</u>

c.

d. | Approximate Interval Between Onset and Death

<u>8 HRS.</u> | | | | | | | | | | | |
| | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
<u>RECENT CORONARY BYPASS SURGERY</u> | | | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | | | | |
| | | | | | | 24e. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | |
| | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation
<input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined
<input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
<u>M</u> | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | |
| | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | | | | | | | |
| 29b. Signature and title of certifier
<u>Benjamin V. Dubois</u> | | 29c. License number
<u>D29391</u> | | 29d. Date signed (Month, Day, Year)
<u>5/24/96</u> | | | | | | | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
<u>BENJAMIN V. DUBOIS 4000 OLD COURT RD. PIKESVILLE, MD. 21208</u> | | | | | | | | | | | | | | |
| 31. Date of Death (Month, Day, Year)
<u>MAY 28 1996</u> | | | | | | | | | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

asp

ITEM: 1. PER FH. FILM G-736

6/11/96 t.t

Item: 1, per F.H. G-735 5/28/96 reb

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 15633

Certificate of Death

Reg. No.

| | | | | | | | |
|--|--|--|---|---|---|---|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
BARBERA BARBARA JEAN IQBAL | | | 2. Date of Death
Month Day Year
MAY 24 1996 | | 3. Time of Death
2255 P | |
| | 4a. Facility Name (If not institution, give street and number)
2506 E. BALTIMORE ST. | | | 4b. City, Town, or Location of Death
BALTIMORE | | 4c. County of Death
N/A | |
| Funeral
Director | 5. Social Security Number
218-58-3971 | | 6. Sex
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)
44 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth (Month, Day, Year)
NOV 1, 1951 |
| | Usual Residence of Decedent | | 9. Birthplace (State or Foreign Country)
Maryland | | | | |
| To Be Completed by Funeral Director | 10a. State
Maryland | | 10b. County
N/A | | 10c. City, Town or Location
Baltimore | | 10d. Inside City Limits
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No |
| | 10e. Street and Number
2506 East Baltimore St. 3rd Floor | | | 10f. Zip Code
21224 | | 10g. Citizen of What Country?
USA | |
| | 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - if Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: White |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 8 College (1-4or 5+) 8 | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Sales Clerk | | 16b. Kind of Business/Industry
Retail Food | | |
| | 17. Father's Name (First, Middle, Last)
Frank Joseph Anthony Wojciechowski, Sr. | | | 18. Mother's Name (First, Middle, Maiden Surname)
Margaret E. Pukaczowski | | | |
| | 19a. Informant's Name/Relationship (Type, Print)
James Douglas Layne/Son | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
90 Pickwick Lane Hardy, VA 24101 | | | |
| | 20a. Method of Disposition
1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Metro Crematory, Inc. 5/26/96 | | 20c. Location - City or Town, State
Baltimore, MD | | |
| | 21. Signature of Funeral Service Licensee
George E. MacNabb | | | 22. Name and Address of Facility
Cremation Society of Maryland, Inc.
299 Frederick Rd. Baltimore, MD 21228 | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

e. Gunshot wounds of head and leg
Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. | | | | | | |
| | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | | | | |
| 24a. Was an autopsy performed?
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death?
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | | | |
| 25. Was case referred to medical examiner?
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | | | |
| 26. Piece of Death (Check only one)
Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. Manner of Death
1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation
2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined
3 <input type="checkbox"/> Suicide 4 <input checked="" type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day Year)
UNK | | 28b. Time of Injury
UNK M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | |
| 28d. Describe how injury occurred
Subject shot | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
Home | | 28f. Location (Street and Number or Rural Route Number, City or Town, State)
2506 E. Baltimore St. | | | |
| 29a. Certifier (Check only one)
1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. Signature and title of certifier
J. Aaron Locke MD | | | 29c. License number
O.C.M.E | | 29d. Date signed (Month, Day, Year)
MAY 25, 1996 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
J. Aaron Locke MD 111 Penn Street, Baltimore, Maryland 21201 | | | | | | | |
| 31. Date of Death
MAY 28 1996 | | | | | | | |
| 32. Registrar's Signature
J. Aaron Locke | | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Certificate of Death

Reg. No.

| | | | | | | | | |
|--|---|---|---|--|--|--|---|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last) RICKY JOHNS, JR. | | | | 2. Date of Death
Month Day Year
MAY 23, 1996 | | 3. Time of Death
22:05 P | |
| | RICKY LEE JOHNS | | | | 4b. City, Town, or Location of Death
BALTIMORE | | 4c. County of Death
N/A | |
| Funeral
Director | 4a. Facility Name (If not institution, give street and number)
5100 BLK. PARK HEIGHTS AVE. | | 5. Social Security Number
220-94-1590 | | 8. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)
16 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. |
| | 9. Birthplace (State or Foreign Country)
Maryland | | 8. Date of Birth (Month, Day, Year)
FEB. 27, 1980 | | | | | |
| To Be Completed by Funeral Director | Usual Residence of Decedent | | | | | | | |
| | 10a. State
Maryland | | 10b. County
N/A | | 10c. City, Town or Location
Baltimore | | | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |
| | 10e. Street and Number
1502 E. 28th Street | | | | 10f. Zip Code
21218 | | 10g. Citizen of What Country?
United States | |
| | 11. Marital Status
<input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: Black | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 11th | | College (1-4 or 5+) -- | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
STUDENT | | 16b. Kind of Business/Industry
School | |
| | 17. Father's Name (First, Middle, Last)
RICKY JOHNS, SR. | | | | 18. Mother's Name (First, Middle, Maiden Surname)
DELOIS HARRIS | | | |
| | 19a. Informant's Name/Relationship (Type, Print)
DELOIS HARRIS | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1502 E. 28th Street, Baltimore, MD 21218 | | | |
| | 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Arbutus Memorial Park | | Data
5-30-96 | | 20c. Location - City or Town, State
Arbutus, MD | |
| | 21. Signature of Funeral Service Licensee
 | | | | 22. Name and Address of Facility
March Funeral Home
1101 E. North Avenue, Baltimore, MD 21202 | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. Multiple Gunshot Wounds
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of): | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | |
| | | | | | | 24e. Was an autopsy performed?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | |
| | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | |
| 25. Was case referred to medical examiner?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) STREET | | | | | | |
| 27. Manner of Death
<input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide
<input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year)
5/23/96 | | 28b. Time of Injury
2145 M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| | | 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
street | | 28d. Describe how injury occurred
Subject shot | | | | |
| | | 28f. Location (Street and Number or Rural Route Number, City or Town, State)
5100 block Park Heights, Baltimore, Maryland | | | | | | |
| 29a. Certifier (Check only one)
<input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier
 | | 29c. License number
OCME | | 29d. Date signed (Month, Day, Year)
MAY 24, 1996 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
THEODORE M. King 111 Penn Street, Baltimore, Maryland 21201 | | | | | | | | |
| 31. Date filed (Month, Day, Year)
MAY 23 1996 | | | | 32. Registrar's Signature
 | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 15635

| | | | | | | | | |
|--|---|--|--|--|---|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
JOSEPH JOHN JAMES | | | | 2. Date of Death
Month MAY Day 25 Year 1996 | | 3. Time of Death
8:01 PM | |
| | 4a. Facility Name (If not institution, give street and number)
St. Agnes Hospital | | | | 4b. City, Town, or Location of Death
Baltimore | | 4c. County of Death
N/A | |
| Funeral
Director | 5. Social Security Number
214-46-2308 | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)
49 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth (Month, Day, Year)
DEC 20, 1946 | 9. Birthplace (State or Foreign Country)
Maryland |
| | Usual Residence of Decedent | | | | | | | |
| 10a. State
Maryland | | 10b. County
Baltimore | | 10c. City, Town or Location
Catonsville | | | 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 10e. Street and Number
20 N. Symington Avenue | | | | 10f. Zip Code
21228 | | 10g. Citizen of What Country?
USA | | |
| 11. Marital Status
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: White | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (1-4or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Care Provider | | 16b. Kind of Business/Industry
Disabled Children | | |
| 17. Father's Name (First, Middle, Last)
William Melvin James | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Myrtle Letrise | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
Marine Lee James/Wife | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
20 N. Symington Ave. Catonsville, MD 21228 | | | | |
| 20a. Method of Disposition
<input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Metro Crematory, Inc. 5/29/96 | | Date | | 20c. Location - City or Town, State
Baltimore, MD | | |
| 21. Signature of Funeral Service Licensee
George E. MacNabb | | | | 22. Name and Address of Facility
MacNabb Funeral Home, P.A.
301 Frederick Rd. Baltimore, MD 21228 | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | | Approximate Interval Between Onset and Death |
| Immediate Cause (Final disease or condition resulting in death) | | | | | | | | |
| a. Hepatic Encephalopathy
Due to (or as a consequence of): | | | | | | | | 2 days |
| b. Liver Failure
Due to (or as a consequence of): | | | | | | | | 2 days |
| c. Cirrhosis of the liver
Due to (or as a consequence of): | | | | | | | | 5 years |
| d. Alcoholism
Due to (or as a consequence of): | | | | | | | | 30 years |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | |
| Gastrointestinal Bleeding | | | | | | | | |
| Esophageal Varices | | | | | | | | |
| 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | | | | |
| 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation
<input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined
<input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input type="checkbox"/> No | | 28d. Describe how injury occurred |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier
William Andrew Renie, MD | | 29c. License number
D23704 | | 29d. Date signed (Month, Day, Year)
May 25, 1996 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
William Andrew Renie, MD St. Agnes Hospital Baltimore, Maryland | | | | | | | | |
| 31. Date filed (Month, Day, Year)
MAY 28 1996 | | 32. Registrar's Signature
William Andrew Renie | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State Registrar

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

96 15636

Reg. No.

| | | | | | | | | |
|---|---|--|---|--|---|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Mary Jane JOYAVE | | | | 2. Date of Death
Month Day Year
May 25 1996 | | 3. Time of Death
8: 20 pm. | |
| | 4a. Facility Name (If not institution, give street and number)
Riverview Nursing Center | | | | 4b. City, Town, or Location of Death
Essex | | 4c. County of Death
Baltimore County | |
| Funeral
Director | 5. Social Security Number
132-24-8377 | | 6. Sex
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday)
72 Yrs. | | 8. Date of Birth (Month, Day, Year)
July 28, 1923 | |
| | 9. Birthplace (State or Foreign Country)
New York | | 10a. State
Md. | | 10b. County
Baltimore | | 10c. City, Town or Location
Essex | |
| To Be Completed by Funeral Director | 10d. Inside City Limits
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 10e. Street and Number
1 Eastern Blvd. | | 10f. Zip Code
21221 | | 10g. Citizen of What Country?
USA | |
| | 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: White | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) College (1-4 or 5+)
12th | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Housewife | | 16b. Kind of Business/Industry
own home | | | |
| | 17. Father's Name (First, Middle, Last)
Daniel Coville | | | | 18. Mother's Name (First, Middle, Maiden Summa)
unknown | | | |
| | 19a. Informant's Name/Relationship (Type, Print)
Sylvia Prachniak | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
4 Barbu Court Baltimore Maryland 21220 | | | |
| | 20a. Method of Disposition
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Holly Hill Cemetery | | Date
5/29/96 | | 20c. Location - City or Town, State
Baltimore Md. | |
| | 21. Signature of Funeral Service Licensee
R. Terry Connelly | | | | 22. Name and Address of Facility
Connelly Funeral Home of Essex
300 Mace Ave. Baltimore MD. 21221 | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only the cause on each line.
Immediate Cause (Final disease or condition resulting in death)
Chronic Obstructive Pulmonary Disease
Due to (or as a consequence of):
a. _____
b. _____
c. _____
d. _____
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | |
| | 23b. Did tobacco use contribute to the cause of death?
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | | | | | |
| | 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | | | | |
| Medical Certification: To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one)
Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | |
| | 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide
5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| | 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| | 29a. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | |
| State Registrar | 29b. Signature and title of certifier
Gerri Davis MD | | | | 29c. License number
2328412-1913 | | 29d. Date signed (Month, Day, Year)
5/25/96 | |
| | 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)
Gerri Davis MD. 9000 Franklin Square Drive, Baltimore, Maryland 21237-3998 | | | | | | | |
| 31. Date filed (Month, Day, Year)
MAY 28 1996 | | 32. Registrar's Signature
[Signature] | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

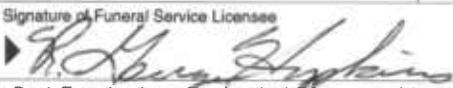
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 15637

| | | | | | | | | | | |
|--|--|--|---|--|--|--|--|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
JAMES Johns | | | | 2. Date of Death
Month MAY Day 26 Year 1996 | | | | 3. Time of Death
12:56 PM | |
| | 4a. Facility Name (If not institution, give street and number)
HARBOR HOSPITAL CENTER | | | | 4b. City, Town, or Location of Death
BALTIMORE | | | | 4c. County of Death
N/A | |
| Funeral
Director | 5. Social Security Number
225-24-5204 | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday)
89 Yrs. | | 8. Date of Birth (Month, Day, Year)
8/26/1906 | | 9. Birthplace (State or Foreign Country)
VIRGINIA | |
| | Usual Residence of Decedent | | | | | | | | | |
| To Be Completed by Funeral Director | 10a. State
NEW JERSEY | | 10b. County
BURLINGTON | | 10c. City, Town or Location
WRIGHTSTOWN | | | | 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| | 10e. Street and Number
B28, 118 COOKSTOWN N.E. ROAD | | | | 10f. Zip Code
08562 | | 10g. Citizen of What Country?
U.S.A. | | | |
| | 11. Marital Status
<input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc.
Specify: WHITE | | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 6 College (1-4 or 5+) NONE | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
MACHINE OPERATOR | | | 16b. Kind of Business/Industry
CHEMICAL PLANT | | | |
| | 17. Father's Name (First, Middle, Last)
JAMES JOHNS | | | | 18. Mother's Name (First, Middle, Maiden Surname)
ELIZABETH JOHNS | | | | | |
| | 19a. Informant's Name/Relationship (Type, Print)
VIOLA N. HICKS (NIECE) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
B28, 118 COOKSTOWN N.E. RD., WRIGHTSTOWN, NJ 08562 | | | | | |
| | 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
GLEN HAVEN | | Date
5/30/96 | | 20c. Location - City or Town, State
GLEN BURNIE, MARYLAND | | | |
| | 21. Signature of Funeral Service Licensee
 | | | | 22. Name and Address of Facility
SINGLETON FUNERAL HOME
1 SECOND AVE. S.W., GLEN BURNIE, MARYLAND 21061 | | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
e. MULTI ORGAN FAILURE
Due to (or as a consequence of):
b. SEPSIS
Due to (or as a consequence of):
c. VOLVULUS SIGMOID COLON
Due to (or as a consequence of):
d. | | | | | | | | | |
| | Approximate Interval Between Onset and Death
5 days
5 days
14 days | | | | | | | | | |
| Physician
/Medical
Examiner | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | |
| | | | | | | | | | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| | | | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| | 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | |
| | 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input type="checkbox"/> No | | 28d. Describe how injury occurred | |
| | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | |
| Medical Certification: To Be Completed by Physician/Medical Examiner | 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | | |
| | 29b. Signature and title of certifier

CHUNG C. NG MD. | | | | 29c. License number
D24076 | | 29d. Date signed (Month, Day, Year)
MAY, 26 1996 | | | |
| | 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)
CHUNG C. NG MD. HARBOR HOSPITAL CENTER 3001 S. HANOVER ST. MD, 21225 | | | | | | | | | |
| | 31. Date filed (Month, Day, Year)
MAY 28 1996 | | 32. Registrar's Signature
 | | | | | | | |

Baltimore, Maryland 21215-0020
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 15638

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Harry Thomas Jones, Jr.

2. Date of Death

May 23 1996

3. Time of Death

5:50 PM

Funeral
Director

4a. Facility Name (If not institution, give street and number)

103 Compass Road

4b. City, Town, or Location of Death

Middle River

4c. County of Death

Baltimore

5. Social Security Number

213-60-2148

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

44

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

May 7, 1952

9. Birthplace (State or Foreign Country)

West Virginia

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Middle River

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10a. Street and Number

103 Compass Road

10f. Zip Code

21220

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Assembler

16b. Kind of Business/Industry

Auto Manufacture

17. Father's Name (First, Middle, Last)

Harry T. Jones Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Winona Collins

19a. Informant's Name/Relationship (Type, Print)

Ida Mae Jones (WIFE)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

103 Compass Road Middle River, Md. 21220

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Holly Hills Mem. Gardens 5/28/1996

Data

20c. Location - City or Town, State

Baltimore Co., Md.

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Bruzdzinski Funeral Home P.A.
1407 Old Eastern Ave. Essex, Md. 21221

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. malignant brain tumor (anaplastic oligodendroglioma) 2 yrs

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

29. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D 31650

29d. Date signed (Month, Day, Year)

5-24-96

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

John Gutheil MD Univ of MD Cancer Center 22 S. Greene St Baltimore MD 21201

State
Registrar

31. Date filed (Month, Day, Year)

MAY 28 1996

32. Registrar's Signature

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Hospital or Attending Physician: The law requires that the death certificate be executed within 72 hours after death. The Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

96 15639

1 FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|---|--|
| 1. DECEASED'S NAME (First, Middle, Last)
RHEA ANTONIETTE KILEY | | | | 2. DATE OF DEATH
MONTH DAY YEAR
May 27, 1996 | | 3. TIME OF DEATH
12:10 A. M | |
| 4. SOCIAL SECURITY NUMBER
293-14-5691 | | 5. SEX
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
90 YRS. | | 7. DATE OF BIRTH (Month, Day, Year)
Jan. 1, 1906 | |
| 8. BIRTHPLACE (State or Foreign Country)
Italy | | | | 9a. FACILITY NAME (If not Institution, give street and number)
Harford Gardens Nursing Home | | 9b. CITY, TOWN OR LOCATION OF DEATH
Baltimore City | |
| 9c. COUNTY OF DEATH
N/A | | | | 10a. STATE
Maryland | | | |
| 10b. COUNTY
N/A | | | | 10c. CITY, TOWN OR LOCATION
Baltimore City | | | |
| 10d. INSIDE CITY LIMITS?
1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | 10e. STREET AND NUMBER
4700 Harford Rd. | | | |
| 10f. ZIP CODE
21214 | | | | 10g. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | |
| 11. MARITAL STATUS
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12) 10 yr's
College (1-4 or 5+) College | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
Homemaker | | 16b. KIND OF BUSINESS/INDUSTRY
Own Home | | | |
| 17. FATHER'S NAME (First, Middle, Last)
Louis Barone | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Althea Barone | | | |
| 19a. INFORMANT'S NAME (Type/Print)
Michael Cornecelli | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
3009 Ailsa Ave. Baltimore, MD 21214 | | | |
| 20a. METHOD OF DISPOSITION
1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
Hilltop Service Corp 5/28/96 | | 20c. LOCATION — City or Town, State
Towson, Md. | | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
Paul L. Hartsock, Jr. | |
| 22. NAME AND ADDRESS OF FACILITY
Baltimore, Maryland 21214 | | 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
IMMEDIATE CAUSE (Final disease or condition resulting in death) →
CHRONIC OBSTRUCTIVE PULMONARY DISEASE
ARITHMIA
CORONARY ARTERY DISEASE
ANEMIA
Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST | | 24a. WAS AN AUTOPSY PERFORMED?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
DEGENERATIVE JOINT DISEASE
DEMENTIA | | | | DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA
OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide
5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one)
1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. SIGNATURE AND TITLE OF CERTIFIER
[Signature] M.D. | | 29c. LICENSE NUMBER
D 31464 | | 29d. DATE SIGNED (Month, Day, Year)
5/28/96 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
STANIS A HARTMAN, 821 N. EUTAW ST Suite 308, Baltimore, MD 21201 | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
MAY 28 1996 | | 32. REGISTRAR'S SIGNATURE
[Signature] | | | | | |

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

4

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 15640

Certificate of Death

Reg. No.

| | | | | | | | | | | |
|---|--|--|--|--|---|--|---|--|---|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Thomas J. Kelly | | | | 2. Date of Death
Month May Day 2 Year 1996 | | | | 3. Time of Death
5:56 PM | |
| | 4a. Facility Name (If not institution, give street and number)
Bel Air Rehabilitation Center | | | | 4b. City, Town, or Location of Death
Bel Air | | | | 4c. County of Death
Harford | |
| Funeral
Director | 5. Social Security Number
066-10-3276 | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday)
82 Yrs. | | 8. Date of Birth (Month, Day, Year)
April 10, 1913 | | 9. Birthplace (State or Foreign Country)
Pennsylvania | |
| | Usual Residence of Decedent | | | | 10a. State
Maryland | | 10b. County
Harford | | 10c. City, Town or Location
Bel Air | |
| To Be Completed by Funeral Director | 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 10e. Street and Number
14 Dallam Avenue | | | | 10f. Zip Code
21014 | |
| | 10g. Citizen of What Country?
U.S.A. | | | | 11. Marital Status
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | | 14. Race - American Indian, Black, White, etc.
Specify: White | | | | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (1-4 or 5+) 1 | |
| | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Executive | | | | 16b. Kind of Business/Industry
Johnson and Johnson | | | | 17. Father's Name (First, Middle, Last)
Michael Kelly | |
| | 18. Mother's Name (First, Middle, Maiden Surname)
unknown | | | | 19a. Informant's Name/Relationship (Type, Print)
Lee Anna Kelly/Wife | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
14 Dallam Avenue-Bel Air, Maryland 21014 | |
| | 20a. Method of Disposition
<input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input checked="" type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) | | | | 20c. Location - City or Town, State | |
| | 21. Signature of Funeral Service Licensee
Ronald S. Wade, Dir. | | | | 22. Name and Address of Facility
State Anatomy Board-655 W. Baltimore Street
Baltimore, Maryland 21201-1559 | | | | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
Metastatic Prostate Cancer | |
| | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| | 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | |
| | 28a. Date of Injury (Month, Day, Year) | | | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | |
| 29b. Signature and title of certifier
DR M.D. | | | | 29c. License number
D34652 | | | | 29d. Date signed (Month, Day, Year)
May 3, 1996 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
SCOTT HASWELL 2 NORTH AVE BEL AIR MARYLAND 21014 | | | | 31. Date filed (Month, Day, Year)
MAY 28 1996 | | | | 32. Registrar's Signature
[Signature] | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

State Registrar

96 15641

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
ANNA V. KOWALSKI | | | | 2. DATE OF DEATH
MONTH DAY YEAR
05 20 96 | | 3. TIME OF DEATH
1:25P M | |
| 4. SOCIAL SECURITY NUMBER
812-28-0961 | | 5. SEX
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
88 YRS. | | 7. DATE OF BIRTH
(Month, Day, Year)
020408 | |
| 9a. FACILITY NAME (If not institution, give street and number)
HOPKINS BAY VIEW GERATRICS | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
BALTIMORE | | 9c. COUNTY OF DEATH
N/A | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE
MARYLAND | | 10b. COUNTY
N/A | | 10c. CITY, TOWN OR LOCATION
BALTIMORE | | 10d. INSIDE CITY LIMITS?
1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER
530 48TH STREET | | | | 10f. ZIP CODE
21224 | | 10g. CITIZEN OF WHAT COUNTRY?
USA | |
| 11. MARITAL STATUS
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify: WHITE | |
| 15. DECEDENT'S EDUCATION
(Specify only highest grade completed)
Elementary/Secondary (9-12) 6 YEARS College (1-4 or 5+) | | | | 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.)
HOMEMAKER | | 16b. KIND OF BUSINESS/INDUSTRY
OWN HOME | |
| 17. FATHER'S NAME (First, Middle, Last)
MARTIN WOJCIOWICZ | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
CAROLINE PARDRO | | | |
| 19a. INFORMANT'S NAME (Type/Print)
MR. RICHARD KOWALSKI | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
406 SCHOOL STREET E. HARFORD, CONN. 06108 | | | |
| 20a. METHOD OF DISPOSITION
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
ST. STANISLAUS CEMETERY | | DATE
5-23 | | 20c. LOCATION — City or Town, State
BALTO. MD. | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
<i>Charles R. Kaczorowski</i> | | | | 22. NAME AND ADDRESS OF FACILITY
KACZOROWSKI FUNERAL HOME
1201 DUNDALK AVE. BALTO. MD. 21222 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | | a. <i>Myocardial Infarction</i> | | | | | |
| | | b. <i>Dementia</i> | | | | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | c. _____ | | | | | |
| | | d. _____ | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA
OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation
2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide
3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Could not be determined
4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M | | 28c. INJURY AT WORK?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28e. DESCRIBE HOW INJURY OCCURRED | | | |
| 29a. CERTIFIER (Check only one)
1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. SIGNATURE AND TITLE OF CERTIFIER
<i>Johns M. Thompson, M.D.</i> | | 29c. LICENSE NUMBER
D47781 | | 29d. DATE SIGNED (Month, Day, Year)
May 20, 1996 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
Johns Hopkins Bayview Medical Center
5505 Hopkins Bayview Circle Baltimore, Maryland 21224 | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
MAY 28 1996 | | 32. REGISTRAR'S SIGNATURE
<i>John A. ...</i> | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

96 15642

Reg. No.

| | | | | | | | | |
|---|--|--|---|--------------------------------|--|---|---|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
LILLIAN MARGARETE KNIGHT | | | | 2. Date of Death
Month Day Year
MAY 21, 1996 | | 3. Time of Death
5:00 PM | |
| | 4a. Facility Name (If not institution, give street and number)
NORTH ARUNDEL
NURSING & REHABILITATION CENTER | | | | 4b. City, Town, or Location of Death
GLEN BURNIE | | 4c. County of Death
ANNE ARUNDEL | |
| Funeral
Director | 5. Social Security Number
220-32-3037 | | 6. Sex
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday)
89 Yrs. | | 8. Date of Birth (Month, Day, Year)
10-03-1906 | |
| | 9. Birthplace (State or Foreign Country)
MARYLAND | | 10a. State
MARYLAND | | 10b. County
N/A | | 10c. City, Town or Location
BALTIMORE | |
| To Be Completed by Funeral Director | 10d. Inside City Limits
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 10e. Street and Number
1101 ST. PAUL STREET, SUITE 2109 | | 10f. Zip Code
21202 | | 10g. Citizen of What Country?
U.S.A. | |
| | 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: WHITE | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 7 | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
FILE CLERK | | 16b. Kind of Business/Industry
ANNE ARUNDEL COUNTY | | | |
| | 17. Father's Name (First, Middle, Last)
JAMES E. HUGGINS | | 18. Mother's Name (First, Middle, Maiden Surname)
CATHERINE | | | | | |
| | 19a. Informant's Name/Relationship (Type, Print)
MRS. ADRIENNE WAHLBRINK | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
6214 EGRET DRIVE, LAKELAND, FLORIDA 33809 | | | | | |
| | 20a. Method of Disposition
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
GLEN HAVEN MEMORIAL PARK | | 20c. Location - City or Town, State
5/25/96 GLEN BURNIE, MD. | | | |
| | 21. Signature of Funeral Service Licensee
 | | 22. Name and Address of Facility
SINGLETON FUNERAL HOME,
1 SECOND AVENUE, S.W., GLEN BURNIE, MD. 21061 | | | | | |
| | 23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. Congestive heart failure
Due to (or as a consequence of):

b.
Due to (or as a consequence of):

c.
Due to (or as a consequence of):

d.
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | Approximate Interval Between Onset and Death
unknown | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Stroke
Aortic stenosis | | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown | | 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | |
| | 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify) | | 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide
5 <input type="checkbox"/> Pending investigation 8 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year)
28b. Time of Injury
M
28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
28d. Describe how injury occurred
28e. Location (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier
 | | 29c. License number
D-40521 | | 29d. Date signed (Month, Day, Year)
May 23, 1996 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
DR OCHANEY
GLEN BURNIE, MD 21061 | | 31. Date filed (Month, Day, Year)
MAY 28 1996 | | 32. Registrar's Signature
 | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 15643

Certificate of Death

Reg. No.

| | | | | | | | | |
|--|--|---|---|--|---|--|--|---|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Ruth M. Kaufman | | | | 2. Date of Death
Month Day Year
May 23, 1996 | | 3. Time of Death
6:00am | |
| | 4a. Facility Name (If not institution, give street and number)
216 Timber Trail | | | | 4b. City, Town, or Location of Death
Belair | | 4c. County of Death
Harford | |
| Funeral
Director | 5. Social Security Number
217-12-5100 | | 6. Sex
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)
72 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth (Month, Day, Year)
Aug/13, 1923 | 9. Birthplace (State or Foreign Country)
Maryland |
| | Usual Residence of Decedent | | | | | | | |
| To Be Completed by Funeral Director | 10a. State
Md. | 10b. County
Harford | 10c. City, Town or Location
Belair | | | 10d. Inside City Limits
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | |
| | 10e. Street and Number
216 Timber Trail | | | 10f. Zip Code
21014 | | 10g. Citizen of What Country?
USA | | |
| | 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: White | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) Collage (1-4or 5+)
12th | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Bindery Inspector | | | 16b. Kind of Business/Industry
H.S. CROcker | |
| | 17. Father's Name (First, Middle, Last)
Jessie Hiser | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Catherine Heibline | | | |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print)
Kitty Raub | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
2519 Karie Lou Drive Kingsville Md. 21087 | | | | |
| | 20e. Method of Disposition
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Gardens of Faith | | Date
5/25/96 | 20c. Location - City or Town, State
Rossville Md. | | |
| | 21. Signature of Funeral Service Licensee
R. Terry Connelly | | | 22. Name and Address of Facility
Connelly Funeral Home of Essex
300 Mace Ave. Baltimore Md. 21221 | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
Immediate Cause (Final disease or condition resulting in death)
a. Adenocarcinoma of unknown primary
Due to (or as a consequence of):
b. Malignant pleural effusions
Due to (or as a consequence of):
c. Respiratory failure
Due to (or as a consequence of):
d.
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | Approximate Interval Between Onset and Death
2 weeks
2 weeks
2 weeks |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Rheumatoid Arthritis
Hypertension | | | | | | | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input checked="" type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown
24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |
| 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide
5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred |
| 29a. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier
Richard Warren Bittick MD | | 29c. License number
D18656 | | 29d. Date signed (Month, Day, Year)
May 24, 1996 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Richard Warren Bittick, MD 8100 Harford Road Balto MD 21234 | | | | | | | | |
| 31. Date filed (Month, Day, Year)
MAY 28 1996 | | 32. Registrar's Signature
Laidson-Rendell | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 15644

Certificate of Death

Reg. No.

| | | | | | | | | |
|---|---|---|--|--|---|--|--|---|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
WILLIAM EDWARD LUMPKIN, Jr. | | | | 2. Date of Death
Month MAY Day 22 Year 1996 | | 3. Time of Death
11 45 AM | |
| | 4e. Facility Name (If not institution, give street and number)
St. Agnes Hospital | | | | 4b. City, Town, or Location of Death
Baltimore | | 4c. County of Death
N/A | |
| Funeral
Director | 5. Social Security Number
217-34-5582 | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)
58 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth
(Month, Day, Year)
Oct. 2, 1937 | 9. Birthplace (State or Foreign Country)
Maryland |
| | Usual Residence of Decedent | | | | | | | |
| 10a. State
Maryland | | 10b. County
N/A | | 10c. City, Town or Location
Baltimore City | | | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | |
| 10e. Street and Number
114 South Clinton Street | | | | 10f. Zip Code
21224 | | 10g. Citizen of What Country?
United States | | |
| 11. Marital Status
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc.
Specify: White | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 2 Years College (1-4 or 5+) 2 Years | | | | 18e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Computer Specialist | | | 16b. Kind of Business/Industry
Computer | |
| 17. Father's Name (First, Middle, Last)
William Edward Lumpkin, Sr. | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Beulah Elizabeth Gayle | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
Mrs. Joyce R. Lumpkin | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
114 S. Clinton Street Baltimore, Maryland 21224 | | | | |
| 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Dulaney Valley Mem. Ph. 5/25/96 | | Date
Timonium, Maryland | | 20c. Location - City or Town, State | | |
| 21. Signature of Funeral Service Licensee
 | | | | 22. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk, Inc.
7922 Wise Ave. Dundalk, Maryland 21222 | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | | Approximate Interval Between Onset and Death |
| Immediate Cause (Final disease or condition resulting in death)
e. HEPATIC ENCEPHALOPATHY
Due to (or as a consequence of): | | | | | | | | 10 months |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. SMALL CELL CARCINOMA of LUNG
Due to (or as a consequence of): | | | | | | | | |
| c. ADENOCARCINOMA colon
Due to (or as a consequence of): | | | | | | | | |
| d. | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | |
| | | | | | | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation
<input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined
<input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred |
| | | 28e. Place of Injury - At home, term, street, tectory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | |
| 29b. Signature and title of certifier
SP MBOUDOU, MD | | 29c. License number
P.O. 7537 | | 29d. Date signed (Month, Day, Year)
MAY 22 1996 | | | | |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)
SP MON MBOUDOU ST AGNES HOSPITAL 900 Caton Avenue Baltimore MD 21229 | | | | | | | | |
| 31. Date filed (Month, Day, Year)
MAY 28 1996 | | 32. Registrar's Signature
 | | | | | | |

96 15645

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | | | | | |
|--|--|---|--|---|--|--|--|---|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
<i>Andre Lawson</i> | | | | 2. DATE OF DEATH
MONTH DAY YEAR
<i>MAY 23, 1996</i> | | | | 3. TIME OF DEATH
<i>1:00 A.M.</i> | | | | | |
| 4. SOCIAL SECURITY NUMBER
<i>213-62-4878</i> | | 5. SEX
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | 6. AGE (In yrs. last birthday)
<i>43</i> YRS. | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 HRS.
HOURS MIN. | | 7. DATE OF BIRTH
(Month, Day, Year)
<i>Jan. 10, 1953</i> | | 8. BIRTHPLACE (State or Foreign Country)
<i>Maryland</i> | | | |
| 9a. FACILITY NAME (If not institution, give street and number)
<i>Joseph Richey Hospice</i> | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
<i>Baltimore</i> | | | | 9c. COUNTY OF DEATH
<i>N/A</i> | | | | | |
| RESIDENCE OF DECEDENT | | | | | | | | | | | | | |
| 10a. STATE
<i>Maryland</i> | | 10b. COUNTY
<i>N/A</i> | | 10c. CITY, TOWN OR LOCATION
<i>Baltimore</i> | | | | 10d. INSIDE CITY LIMITS?
<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | | | | |
| 10e. STREET AND NUMBER
<i>1035 N. Central Avenue</i> | | | | 10f. ZIP CODE
<i>21202</i> | | | | 10g. CITIZEN OF WHAT COUNTRY?
<i>USA</i> | | | | | |
| 11. MARITAL STATUS
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | | | 14. RACE — American Indian, Black, White, etc.
Specify: <i>Negro</i> | | | | | |
| 15. DECEDENT'S EDUCATION
(Specify only highest grade completed)
Elementary/Secondary (0-12) <i>12</i> College (1-4 or 5+) <i>0</i> | | | | 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.)
<i>Driveway Attendant</i> | | | | 16b. KIND OF BUSINESS/INDUSTRY
<i>Quille's Amoco</i> | | | | | |
| 17. FATHER'S NAME (First, Middle, Last)
<i>Clyde Lawson</i> | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
<i>Beverly Taylor</i> | | | | | | | | | |
| 19a. INFORMANT'S NAME (Type/Print)
<i>Mrs. Cherel Lawson</i> | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
<i>1035 N. Central Ave. Balto. Md. 21202</i> | | | | | | | | | |
| 20a. METHOD OF DISPOSITION
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematorium, or other place)
<i>MT. Zion 5/29/96</i> | | 20c. LOCATION — City or Town, State
<i>Lansdowne, Md.</i> | | | | | | | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
<i>Joseph L. Russ</i> | | | | 22. NAME AND ADDRESS OF FACILITY
<i>Joseph L. Russ Funeral Home 2222 W. North Ave. Balto. Md. 21216</i> | | | | | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>MULTI FOCAL LEUKOENCEPHALOPATHY</i>

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
<i>AIDS</i> | | | | | | | | | | Approximate Interval Between Onset and Death
<i>3 MONTHS YEARS.</i> | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | | | | | | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/> | | | | | | | | | | 24a. WAS AN AUTOPSY PERFORMED?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
<input type="checkbox"/> YES <input type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <i>HOSPITAL</i> | | | | | | | | | | | |
| 27. MANNER OF DEATH
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY
(Month, Day, Year) | | 28b. TIME OF INJURY
M | | 28c. INJURY AT WORK?
<input type="checkbox"/> YES <input type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | | | | | |
| 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | | |
| 29a. CERTIFIER (Check only one)
<input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
<i>Dr. Donald S. [Signature]</i> | | | | 29c. LICENSE NUMBER
<i>D 06933</i> | | | | 29d. DATE SIGNED (Month, Day, Year)
<i>MAY 23 1996</i> | | | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
<i>JOHN B. MCGIBSON MD 101 W READING ST SUITE 19 BALTIMORE MD 21201</i> | | | | | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
<i>MAY 28 1996</i> | | | | 32. REGISTRAR'S SIGNATURE
<i>Julia Davidson-Randall</i> | | | | | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

ITEM: 17. PER F.H.
FILM G-735 5/28/96 t.t

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

96 15646

Reg. No.

| | | | | | | | | | |
|--|--|---|--|--|---|---|---|---|---|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
HUBERT LATIMORE | | | | 2. Date of Death
Month May Day 21 Year 1996 | | 3. Time of Death
8:00 am | | |
| | 4a. Facility Name (If not institution, give street and number)
447 N. Ellwood Avenue | | | | 4b. City, Town, or Location of Death
Baltimore | | 4c. County of Death
N/A | | |
| Funeral
Director | 5. Social Security Number
259-28-3490 | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)
73 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth
(Month, Day, Year)
Jan. 9, 1923 | 9. Birthplace (State or Foreign Country)
Georgia | |
| | Usual Residence of Decedent | | | | | | | | |
| 10a. State
Maryland | | 10b. County
N/A | | 10c. City, Town or Location
Baltimore | | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | |
| 10e. Street and Number
447 N. Ellwood Avenue | | | | 10f. Zip Code
21224 | | 10g. Citizen of What Country?
United States | | | |
| 11. Marital Status
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
If Yes, Give Year or Dates: ARMY unk. | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: Black | | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12th College (1-4or 5+) - | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Laborer | | 16b. Kind of Business/Industry
General Motors | | | |
| 17. Father's Name (First, Middle, Last)
Carnelzar Latimore CARNAZAR LATIMORE | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Orabell Bailey | | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
Selena Stokes | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
447 N. Ellwood Avenue, Baltimore, MD 21224 | | | | | |
| 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
GARRISON FORREST VA CEM. 5-24 | | Date | | 20c. Location - City or Town, State
OWINGS MILLS, MD | | | |
| 21. Signature of Funeral Service Licensee
 | | | | 22. Name and Address of Facility
March Funeral Home
1101 E. North Avenue, Baltimore, MD 21202 | | | | | |
| 23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. Acute Myocardial Infarction
Due to (or as a consequence of):
b. Coronary Heart Failure
Due to (or as a consequence of):
c. Hypertension
Due to (or as a consequence of):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Dementia
Aortic atherosclerosis | | | | | | | | Approximate Interval Between Onset and Death | |
| 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | | | | | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation
<input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined
<input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input type="checkbox"/> No | | 28d. Describe how injury occurred | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier
Dr. Hubert Latimore MD | | | | | | 29c. License number
120748 | 29d. Date signed (Month, Day, Year)
5/23/96 |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
ANIL UBEROIE MD 4410 FALLS RD BALTO MD 21221 | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
MAY 28 1996 | | 32. Registrar's Signature
 | | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 15647

Certificate of Death

Reg. No.

| | | | | | | | |
|---|---|--|--|---|---|---|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
DANIEL J. LORDEN | | | 2. Date of Death
Month Day Year
MAY 21 1996 | | 3. Time of Death
9:55 AM | |
| | 4a. Facility Name (If not institution, give street and number)
1110 S. BOULDIN ST. | | | 4b. City, Town, or Location of Death
BALTIMORE | | 4c. County of Death
N/A | |
| Funeral
Director | 5. Social Security Number
213-05-5303 | | 6. Sex
1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | 7. Age (In yrs. last birthday)
80 Yrs. | 8. Date of Birth (Month, Day, Year)
OCT. 27, 1915 | 9. Birthplace (State or Foreign Country)
MD. | |
| | Usual Residence of Decedent | | | | | | |
| To Be Completed by Funeral Director | 10a. State
MD. | | 10b. County
N/A | | 10c. City, Town or Location
BALTIMORE | | 10d. Inside City Limits
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No |
| | 10e. Street and Number
1110 S. BOULDIN ST. | | | 10f. Zip Code
21224 | | 10g. Citizen of What Country?
U-S-A | |
| | 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No
If Yes, Give Year or Dates: WWII | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: WHITE |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) College (1-4 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
WARE HOUSEMAN | | 16b. Kind of Business/Industry
BREWERY | | |
| | 17. Father's Name (First, Middle, Last)
BARTHOLOMEW LORDEN | | | 18. Mother's Name (First, Middle, Maiden Surname)
ANASTASIA KEENAN | | | |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print)
DIANE CORKRAN | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
4326 WINTHROP WAY BALTO. MD. 21236 | | | |
| | 20a. Method of Disposition
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
ST-STANISLAUS | | 20c. Location - City or Town, State
BALTO. CO MD | | |
| | 21. Signature of Funeral Service Licensee
[Signature] | | | 22. Name and Address of Facility
SKARDA F.H. 1829 HUDSON ST. BALTO MD. 21224 | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. myocardial infarction
Due to (or as a consequence of):
b. arteriosclerosis
c. chronic atrial fibrillation
Due to (or as a consequence of):
d.
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last | | | | | | |
| | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | |
| 25. Was case referred to medical examiner?
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | 26. Place of Death (Check only one)
Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | |
| 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide
5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how Injury occurred |
| | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier
Walter Koppel MD | | 29c. License number
D15538 | | 29d. Date signed (Month, Day, Year)
5/23/96 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Walter Koppel, MD 1900 E. NORTHERN PKWY BALTO MD 21237 | | | | | | | |
| 31. Date filed (Month, Day, Year)
MAY 28 1996 | | 32. Registrar's Signature
[Signature] | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

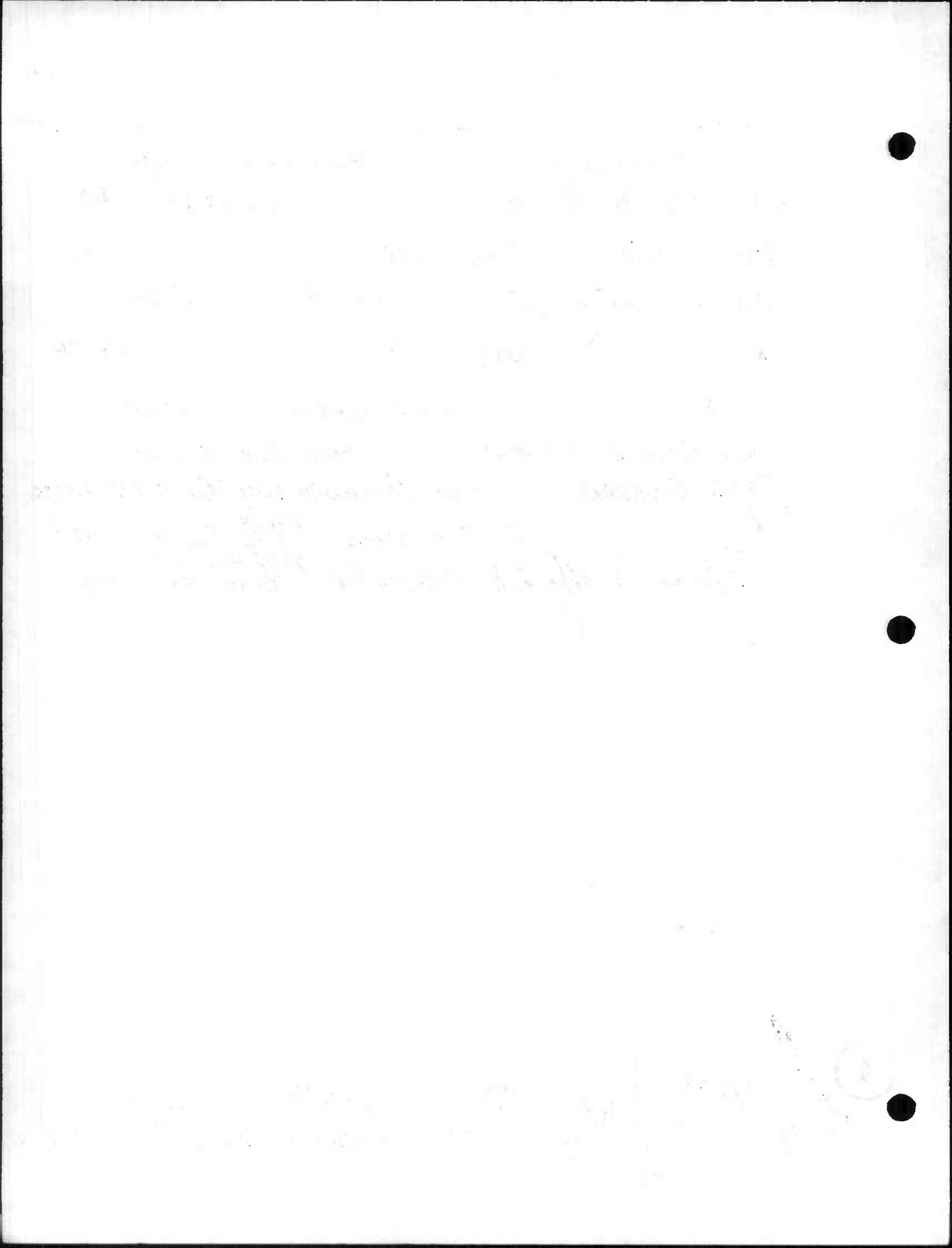
Division of Vital Records, P.O. Box 68760,

Training Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and duly filed in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

12

State
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 15648

| | | | | | | | | | |
|---|--|---|---|--|---|--|--|---|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
FRANKLIN SUENG LEE | | | | 2. Date of Death
Month Day Year
MAY 23, 1996 | | 3. Time of Death
9:30 P.M. | | |
| | 4a. Facility Name (If not institution, give street and number)
NORTH ARUNDEL HOSPITAL | | | | 4b. City, Town, or Location of Death
GLEN BURNIE | | 4c. County of Death
ANNE ARUNDEL | | |
| Funeral
Director | 5. Social Security Number
220-78-9125 | | 6. Sex
1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | 7. Age (In yrs. last birthday)
64 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth
(Month, Day, Year)
9-12-1931 | 9. Birthplace (State or Foreign Country)
KOREA | |
| | Usual Residence of Decedent | | | | | | | | |
| 10a. State
MARYLAND | | 10b. County
ANNE ARUNDEL | | 10c. City, Town or Location
SEVERN | | | 10d. Inside City Limits
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | |
| 10e. Street and Number
8160 SILO ROAD | | | | 10f. Zip Code
21144 | | 10g. Citizen of What Country?
U.S.A. | | | |
| 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc.
Specify: KOREAN | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) College (1-4or 5+)
12 3 | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
OWNER | | | 16b. Kind of Business/Industry
TRANSPORTATION COMPANY | | |
| 17. Father's Name (First, Middle, Last)
HYNN HWI | | | | 18. Mother's Name (First, Middle, Maiden Surname)
LEE UNKNOWN | | CHOI | | | |
| 19a. Informant's Name/Relationship (Type, Print)
SANG YOON LEE | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
8160 SILO ROAD, SEVERN, MARYLAND 21144 | | | | | |
| 20a. Method of Disposition
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
MEADOWRIDGE MEMORIAL PARK | | | 20c. Location - City or Town, State
ELKRIDGE, MARYLAND | | | |
| 21. Signature of Funeral Service Licensee
 | | | | 22. Name and Address of Facility
SINGLETON FUNERAL HOME,
1 SECOND AVENUE, S.W., GLEN BURNIE, MD. 21061 | | | | | |
| 23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

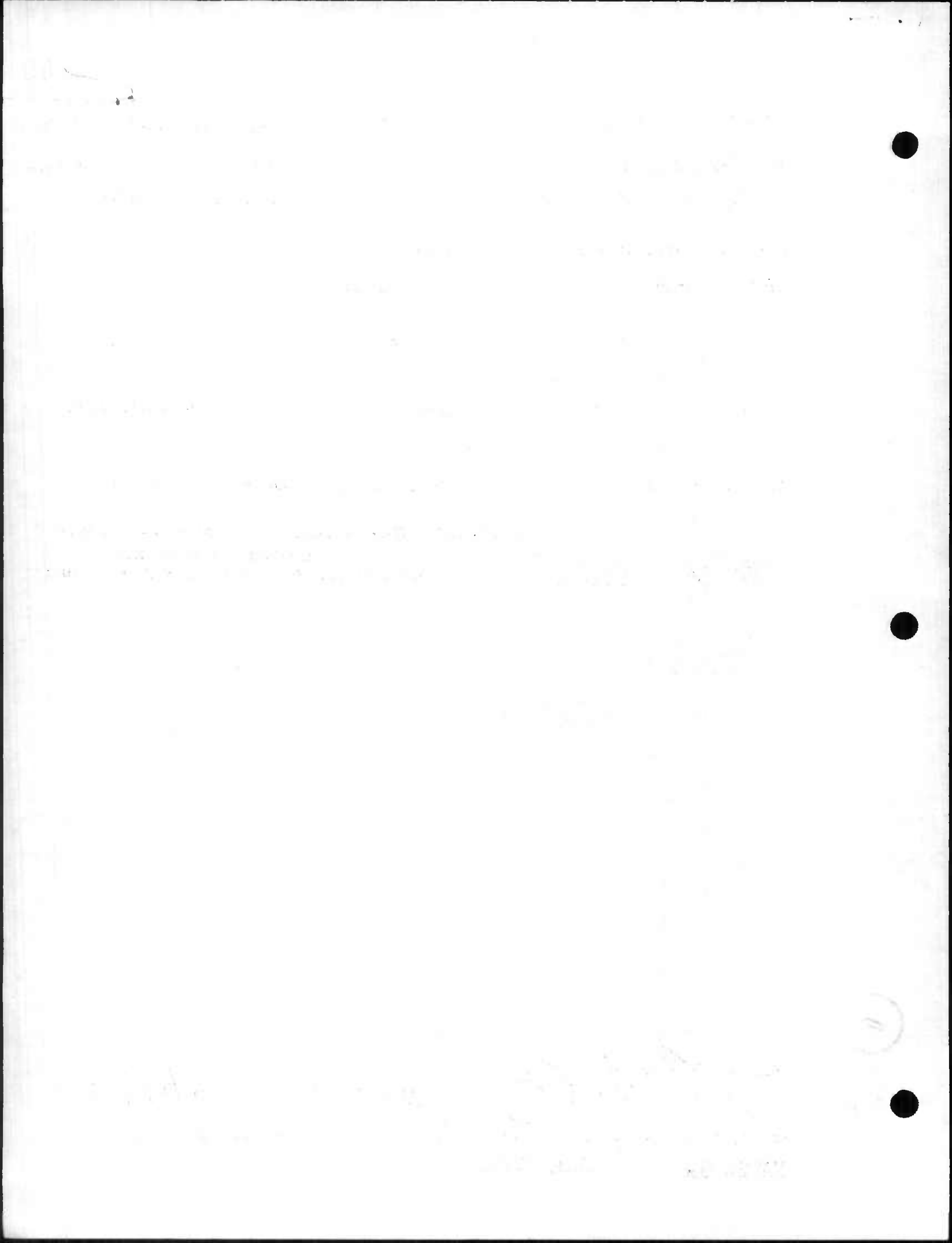
Immediate Cause (Final disease or condition resulting in death)
a. <i>Acute Myocardial infarction</i>
Due to (or as a consequence of):
b. <i>with preexisting atherosclerosis</i>
Due to (or as a consequence of):
c. <i>due to coronary artery disease</i>
Due to (or as a consequence of):
d.

Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last | | | | | | | | Approximate Interval Between Onset and Death | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
<i>Coronary artery disease</i>
<i>Hypertension</i> | | | | | | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown | | | |
| 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | |
| 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. Manner of Death
1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide
5 <input type="checkbox"/> Pending investigation 8 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how Injury occurred | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier
 | | 29c. License number
202583 | | 29d. Date signed (Month, Day, Year)
5/24/96 | | | |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)
DR. A. S. SUBONG, M.D., 206 CRAIN HIGHWAY, S.W., GLEN BURNIE, MD. 21061 | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
MAY 28 1996 | | 32. Registrar's Signature
 | | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

10



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 15649

Certificate of Death

Reg. No.

| | | | | | | | | | |
|---|--|---|---|---|--|---|--|---|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Regina Lehner | | | | 2. Date of Death
Month Day Year
May 24, 1996 | | 3. Time of Death
2:30am | | |
| | 4a. Facility Name (If not institution, give street and number)
1109 Chesaco Ave. | | | | 4b. City, Town, or Location of Death
Rosedale | | 4c. County of Death
Baltimore | | |
| Funeral
Director | 5. Social Security Number
220808691 | | 6. Sex
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)
82 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth (Month, Day, Year)
Sept. 7, 1913 | 9. Birthplace (State or Foreign Country)
MARYLAND | |
| | Usual Residence of Decedent | | | | | | | | |
| To Be Completed by Funeral Director | 10a. State
MD | | 10b. County
Baltimore | | 10c. City, Town or Location
Rosedale | | 10d. Inside City Limits
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | |
| | 10e. Street and Number
1109 Chesaco Ave. | | | | 10f. Zip Code
21237 | | 10g. Citizen of What Country?
USA | | |
| | 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: white | | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (1-4 or 5+) <input type="checkbox"/> | | 18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
HOUSEWIFE | | 16b. Kind of Business/Industry
OWN HOME | | | | |
| | 17. Father's Name (First, Middle, Last)
Michael Stuprich | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Magdalenena Weisner | | | | |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print)
Joanne M. Varley/Daughter | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1700 Watervale Road, Falston, Md 21047 | | | | |
| | 20a. Method of Disposition
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify): | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Gardens of Faith | | Date
5-28-96 | | 20c. Location - City or Town, State
Baltimore, MD | | |
| | 21. Signature of Funeral Service Licensee | | | | 22. Name and Address of Facility
Cvach/Rosedale Funeral Home
1211 Chesaco Ave. Baltimore, Md 21237 | | | | |
| | 23a. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
<u>metastatic lymphoma</u>
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. | | | | | | | | |
| | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 28. Place of Death (Check only one)
Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation
2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined
3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of injury
M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 28d. Describe how Injury occurred | |
| 29a. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier | | 29c. License number
D34931 | | 29d. Date signed (Month, Day, Year)
05-24-96 | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Ann C. Morrill 1224 Chesaco Ave Baltimore, Md 21237 | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
MAY 28 1996 | | State Registrar | | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completed, filed in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 15650

Certificate of Death

Reg. No.

| | | | | | | | | | | | | | | | | | | | |
|--|---|--|---|---|--|---|---|---|---|--|--------------|---|---|--------------|---|--------------|--|--------------|----|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
MARY JANE C. MADDEN | | | | 2. Date of Death
Month MAY Day 26 Year 1996 | | 3. Time of Death
3:17 am | | | | | | | | | | | | |
| | 4a. Facility Name (If not institution, give street and number)
SAINT JOSEPH MEDICAL CENTER | | | | 4b. City, Town, or Location of Death
TOWSON | | 4c. County of Death
BALTIMORE | | | | | | | | | | | | |
| Funeral
Director | 5. Social Security Number
214-44-5331 | 8. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)
51 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth (Month, Day, Year)
July 13, 1944 | | 9. Birthplace (State or Foreign Country)
Maryland | | | | | | | | | | | |
| | Usual Residence of Decedent | | | | | | | | | | | | | | | | | | |
| To Be Completed by Funeral Director | 10a. State
Maryland | 10b. County
Baltimore | 10c. City, Town or Location
Baltimore | | | 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | | | | | | |
| | 10e. Street and Number
3106 Edgewood Avenue | | | 10f. Zip Code
21234 | | 10g. Citizen of What Country?
United States | | | | | | | | | | | | | |
| | 11. Marital Status
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: White | | | | | | | | | | | | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (1-4or 5+) 4 | | 18e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Teacher | | | 16b. Kind of Business/Industry
Archdiocese | | | | | | | | | | | | | |
| | 17. Father's Name (First, Middle, Last)
Stefano P. Valerio | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Mary O. D'Angelo | | | | | | | | | | | | | | |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print)
Donald R. Madden/ Husband | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
3106 Edgewood Avenue Baltimore, Md. 21234 | | | | | | | | | | | | | | | |
| | 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
St. Joseph's Fullerton Cemetery | | Date
5/29/96 | | 20c. Location - City or Town, State
Baltimore, Maryland | | | | | | | | | | | | |
| | 21. Signature of Funeral Service Licensee
Brian A. Willem | | | 22. Name and Address of Facility
Leonard J. Ruck Funeral Home, Inc.
5305 Harford Road Baltimore, Maryland 21214 | | | | | | | | | | | | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | | | | | | | | | | | | |
| | <table border="1"> <tr> <td>Immediate Cause (Final disease or condition resulting in death)</td> <td>HYPERTENSIVE CONGESTIVE HEART FAILURE</td> <td>YEARS</td> </tr> <tr> <td rowspan="4">Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last</td> <td>a. Due to (or as a consequence of):
DIABETIC NEPHROPATHY, END STAGE</td> <td>YEARS</td> </tr> <tr> <td>b. Due to (or as a consequence of):
CHRONIC OBSTRUCTIVE PULMONARY DISEASE</td> <td>YEARS</td> </tr> <tr> <td>c. Due to (or as a consequence of):
ANEMIA, SECONDARY TO RENAL DISEASE</td> <td>YEARS</td> </tr> <tr> <td>d.</td> <td></td> </tr> </table> | | | | | | | | Immediate Cause (Final disease or condition resulting in death) | HYPERTENSIVE CONGESTIVE HEART FAILURE | YEARS | Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | a. Due to (or as a consequence of):
DIABETIC NEPHROPATHY, END STAGE | YEARS | b. Due to (or as a consequence of):
CHRONIC OBSTRUCTIVE PULMONARY DISEASE | YEARS | c. Due to (or as a consequence of):
ANEMIA, SECONDARY TO RENAL DISEASE | YEARS | d. |
| Immediate Cause (Final disease or condition resulting in death) | HYPERTENSIVE CONGESTIVE HEART FAILURE | YEARS | | | | | | | | | | | | | | | | | |
| Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | a. Due to (or as a consequence of):
DIABETIC NEPHROPATHY, END STAGE | YEARS | | | | | | | | | | | | | | | | | |
| | b. Due to (or as a consequence of):
CHRONIC OBSTRUCTIVE PULMONARY DISEASE | YEARS | | | | | | | | | | | | | | | | | |
| | c. Due to (or as a consequence of):
ANEMIA, SECONDARY TO RENAL DISEASE | YEARS | | | | | | | | | | | | | | | | | |
| | d. | | | | | | | | | | | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
PULMONARY HYPERTENSION
HYPERCHOLESTEROLEMIA/HYPERTRIGLYCERIDEMIA | | | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | | | | | | | | | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | 26. Place of Death (Check only one)
Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | | | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | | | | | | | | | | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier
Ceballos, MD | | 29c. License number
D 25886 | | 29d. Date signed (Month, Day, Year)
5-26-96 | | | | | | | | | | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
LILIA CEBALLOS, M.D. 7620 YORK ROAD TOWSON, MARYLAND 21204 | | | | | | | | | | | | | | | | | | | |
| State Registrar | 31. Date filed (Month, Day, Year)
MAY 28 1996 | | 32. Registrar's Signature
Lilia Ceballos-Rodriguez
15 | | | | | | | | | | | | | | | | |

1. The first part of the report is a general introduction to the subject of the study. It discusses the importance of the problem and the objectives of the research. It also mentions the scope of the study and the methods used.

2. The second part of the report is a detailed description of the experimental work. It includes a description of the apparatus used, the procedure followed, and the results obtained. It also discusses the errors and the limitations of the experiment.

3. The third part of the report is a discussion of the results. It compares the results with the theoretical predictions and with the results of other experiments. It also discusses the implications of the results and the conclusions drawn from the study.

4. The fourth part of the report is a conclusion. It summarizes the main findings of the study and states the conclusions drawn from the results. It also mentions the suggestions for further work.

5. The fifth part of the report is a list of references. It includes the names of the authors and the titles of the books and articles referred to in the report.

6. The sixth part of the report is an appendix. It contains the raw data and the calculations used in the study. It also includes a list of symbols and abbreviations used in the report.

Certificate of Death

Reg. No.

| | | | | | | | | | | |
|--|--|--|---|--|--|--------------------------------|---|--|---|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
<i>Catherine A. T. Montgomery</i> | | | | | | 2. Date of Death
Month <i>May</i> Day <i>20</i> Year <i>1996</i> | | 3. Time of Death
<i>11:20 p.m.</i> | |
| | 4a. Facility Name (If not institution, give street and number)
<i>Old Court Nursing Home</i> | | | | | | 4b. City, Town, or Location of Death
<i>NIA</i> | | 4c. County of Death
<i>Balto</i> | |
| Funeral
Director | 5. Social Security Number
<i>214-40-4999</i> | | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)
<i>80</i> Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth
<i>MARCH 14, 1916</i> | | 9. Birthplace (State or Foreign Country)
<i>md</i> | |
| | Usual Residence of Decedent | | | | | | | | | |
| To Be Completed by Funeral Director | 10a. State
<i>md</i> | | 10b. County
<i>Balto</i> | | 10c. City, Town or Location
<i>NIA</i> | | | 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| | 10e. Street and Number
<i>5512 Old Ct Rd.</i> | | | | 10f. Zip Code
<i>21207 21133</i> | | 10g. Citizen of What Country?
<i>U.S.A</i> | | | |
| | 11. Marital Status
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc.
Specify: <i>Black</i> | | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) <i>12th</i> College (1-4 or 5+) <i>NIA</i> | | | | 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
<i>Teacher</i> | | | 16b. Kind of Business/Industry
<i>Balto Public School</i> | | |
| | 17. Father's Name (First, Middle, Last)
<i>Harrison Tucker</i> | | | | | | 18. Mother's Name (First, Middle, Maiden Surname)
<i>Alice Marie</i> | | | |
| Physician
/Medical
Examiner | 19a. Informant's Name/Relationship (Type, Print)
<i>Harrison Tucker III-nephew</i> | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
<i>12203 Greenshoot Ct. Columbia, md 21044</i> | | | | | |
| | 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
<i>King Memorial Pl</i> | | 20c. Date
<i>5/30/96</i> | | 20d. Location - City or Town, State
<i>Randallstown, md</i> | | | |
| | 21. Signature of Funeral Service Licensee
<i>Gabrielle Cook</i> | | | | 22. Name and Address of Facility
<i>March A H-west
4300 Wabash Ave</i> | | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | | | |
| | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | | | | | | | | |
| Medical Certification: To Be Completed by Physician/Medical Examiner | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | | | |
| | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | | | | | | | | |
| | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | | |
| | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | | |
| | 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | | |
| Division of Vital Records, P.O. Box 68760, | 26. Piece of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | | | |
| | 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation
<input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined
<input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | |
| | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| | 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | |
| | 29b. Signature and title of certifier
<i>Jeff Ormby</i> | | | | 29c. License number
<i>D20964</i> | | 29d. Date signed (Month, Day, Year)
<i>5-28-96</i> | | | |
| State Registrar | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
<i>Jerome H. Ginsberg, M.D.
8630 Liberty Plaza Mall
Randallstown, MD 21133</i> | | | | | | | | | |
| | 31. Date filed (Month, Day, Year)
<i>MAY 28 1996</i> | | | | 32. Registrar's Signature
<i>John Davidson-Randall</i> | | | | | |

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

ITEMS: 16a,16b, PER F.H. FILM G-736 State of Maryland / Department of Health and Mental Hygiene

96 15652

6/4/96 t.t

Certificate of Death

Reg. No.

| | | | | | | | | | | |
|---|---|--|---|--|--|---|---|---|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
William V. MOYER Jr. | | | | | | 2. Date of Death
Month Day Year
May 26, 1996 | | 3. Time of Death
1:21 am | |
| | 4a. Facility Name (If not institution, give street and number)
Franklin Square Hospital | | | | | | 4b. City, Town, or Location of Death
Rossville | | 4c. County of Death
Baltimore County | |
| Funeral
Director | 5. Social Security Number
212-48-2182 | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday)
47 Yrs. | | 8. Date of Birth (Month, Day, Year)
Sept. 17, 1948 | | 9. Birthplace (State or Foreign Country)
Maryland | |
| | Usual Residence of Decedent | | | | | | | | | |
| 10a. State
Md. | | | 10b. County
Baltimore | | | 10c. City, Town or Location
Middle River | | | 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 10e. Street and Number
2121 Oakland Ave. | | | 10f. Zip Code
21220 | | | 10g. Citizen of What Country?
USA | | | | |
| 11. Marital Status
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc.
Specify: White | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12th
College (1-4or 5+) | | | 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
FAULT LOCATOR | | | 16b. Kind of Business/Industry
BALTIMORE GAS & ELECTRIC
BCE | | | | |
| 17. Father's Name (First, Middle, Last)
William V. Moyer Sr. | | | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Antoinette Cernohorsky | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
Angela Moyer | | | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
2121 Oakland Ave. Baltimore Maryland 21220 | | | | |
| 20a. Method of Disposition
<input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Metro Crematory Inc. | | | Date
5/29/96 | | 20c. Location - City or Town, State
Baltimore MD. | | |
| 21. Signature of Funeral Service Licensee
R. Terry Connelly | | | 22. Name and Address of Facility
Connelly Funeral Home of Essex
300 Mace Ave. Baltimore Md. 21221 | | | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. ACUTE MYOCARDIAL INFARCTION
Due to (or as a consequence of):

b.
Due to (or as a consequence of):

c.
Due to (or as a consequence of):

d. | | | | | | | | | | |
| 23b. Did tobacco use contribute to the cause of death?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | | | | | | |
| 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
HYPERTENSION | | | | | | | | | | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation
<input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined
<input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | |
| | | | 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | | | |
| 29b. Signature and title of certifier
John D.O. | | | 29c. License number
H35593 | | | 29d. Date signed (Month, Day, Year)
MAY 28, 1996 | | | | |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)
DR. JOHN J. LOH 1124 MACE AVE., BALTIMORE, MARYLAND 21221 | | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
MAY 28 1996 | | | 32. Registrar's Signature
John D.O. | | | | | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed with 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 15653

Certificate of Death

Reg. No.

| | | | | | | | | |
|--|---|--|--|---|---|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
MAGGIE BEATRICE MOORE | | | | 2. Date of Death
Month May Day 26 Year 1996 | | 3. Time of Death
10:45 a.m. | |
| | 4a. Facility Name (If not institution, give street and number)
3905 COLBORNE ROAD | | | | 4b. City, Town, or Location of Death
BALTIMORE | | 4c. County of Death
N/A | |
| Funeral
Director | 5. Social Security Number
241-34-4322 | | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday)
80 Yrs. | | 8. Date of Birth (Month, Day, Year)
May 31, 1915 | |
| | 9. Birthplace (State or Foreign Country)
N. Carolina | | 10a. State
MD | | 10b. County
N/A | | 10c. City, Town or Location
Baltimore | |
| Usual Residence of Decedent | | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 10e. Street and Number
3905 Colborne Road | | 10f. Zip Code
21229 | | |
| 10g. Citizen of What Country?
USA | | 11. Marital Status
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | |
| 14. Race - American Indian, Black, White, etc.
Specify: Black | | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 11th
College (1-4 or 5+) N/A | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
N/A | | 16b. Kind of Business/Industry
N/A | | |
| 17. Father's Name (First, Middle, Last)
William McDougould | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Maggie McDougould | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
Calvin Wilson/son-in-law | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
142 S. Kossuth Street, Balto., MD. 21229 | | | | |
| 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Mt. Zion Cemetery | | Date
6/1/96 | | 20c. Location - City or Town, State
Baltimore, Maryland | | |
| 21. Signature of Funeral Service Licensee
Leroy O. Dyett Jr. | | | | 22. Name and Address of Facility
LEROY O. DYETT & SON FUNERAL HOME, P.A.
4600 LIBERTY HEIGHTS AVE, BALTO. 21207 | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
e. Metastatic Breast Cancer
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of): | | | | | | | | |
| 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | | | | |
| 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | |
| 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicidal <input type="checkbox"/> Homicide
<input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | |
| 29b. Signature and title of certifier
[Signature] | | 29c. License number
D20215 | | 29d. Date signed (Month, Day, Year)
5/28/96 | | | | |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)
Karmachandha Nair, M.D. 1190 W. Northern Parkway | | | | | | | | |
| 31. Date filed (Month, Day, Year)
MAY 28 1996 | | | | | | | | |
| 32. Registrar's Signature
[Signature] | | | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 15654

Certificate of Death

Reg. No.

| | | | | | | | | | | |
|--|---|------------------------------------|---|--|--|---|--|--|---|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Richard J. Matter, Sr. | | | | | | 2. Date of Death
Month Day Year
May 27 1996 | | 3. Time of Death
12:35PM | |
| | 4a. Facility Name (If not Institution, give street and number)
North Arundel Hospital | | | | | | 4b. City, Town, or Location of Death
Glen Burnie | | 4c. County of Death
Anne Arundel | |
| Funeral
Director | 5. Social Security Number
217-16-4560 | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday)
74 Yrs. | | 8. Date of Birth (Month, Day, Year)
1/20/22 | | 9. Birthplace (State or Foreign Country)
MARYLAND | |
| | Usual Residence of Decedent | | | | | | | | | |
| 10a. State
MARYLAND | | 10b. County
ANNE ARUNDEL | | 10c. City, Town or Location
MILLERSVILLE | | | | 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 10e. Street and Number
18 ROL-PARK TRAILER VILLAGE | | | | 10f. Zip Code
21108 | | 10g. Citizen of What Country?
U.S.A. | | | | |
| 11. Marital Status
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | | 12. Was Decedent Ever in U.S. Armed Forces?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc.
Specify: WHITE | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 8 College (1-4or 5+) NONE | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
CAR SALESMAN | | | 16b. Kind of Business/Industry
CAR | | | |
| 17. Father's Name (First, Middle, Last)
CHARLES MATTER | | | | | | 18. Mother's Name (First, Middle, Maiden Surname)
DAISY (UNKNOWN) | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
MRS. MARY K. MATTER | | | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
18 ROL PARK TRAILER VILLAGE, MILLERSVILLE, MD 21108 | | | | |
| 20a. Method of Disposition
<input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
CHESAPEAKE CREMATORY | | | 20c. Date
5/30/96 | | 20d. Location - City or Town, State
BELTSVILLE, MARYLAND | | |
| 21. Signature of Funeral Service Licensee
 | | | | | | 22. Name and Address of Facility
SINGLETON FUNERAL HOME
1 SECOND AVE. S.W., GLEN BURNIE, MD 21061 | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. CONGESTIVE HEART FAILURE
Due to (or as a consequence of):
b. CORONARY HEART DISEASE
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
DIABETES MELLITUS | | | | | | | | | | |
| 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | | | | | | |
| 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | | | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | 26. Place of Death (Check only one)
Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input type="checkbox"/> No | | 28d. Describe how injury occurred | |
| | | | 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | 29b. Signature and title of certifier
 MD | | | 29c. License number
D43977 | | 29d. Date signed (Month, Day, Year)
May 27th 1996 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
ANDREW OKETUNJI, 301 HOSPITAL DRIVE, GLEN BURNIE, MD 21061 | | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
MAY 28 1996 | | | 32. Registrar's Signature
 | | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

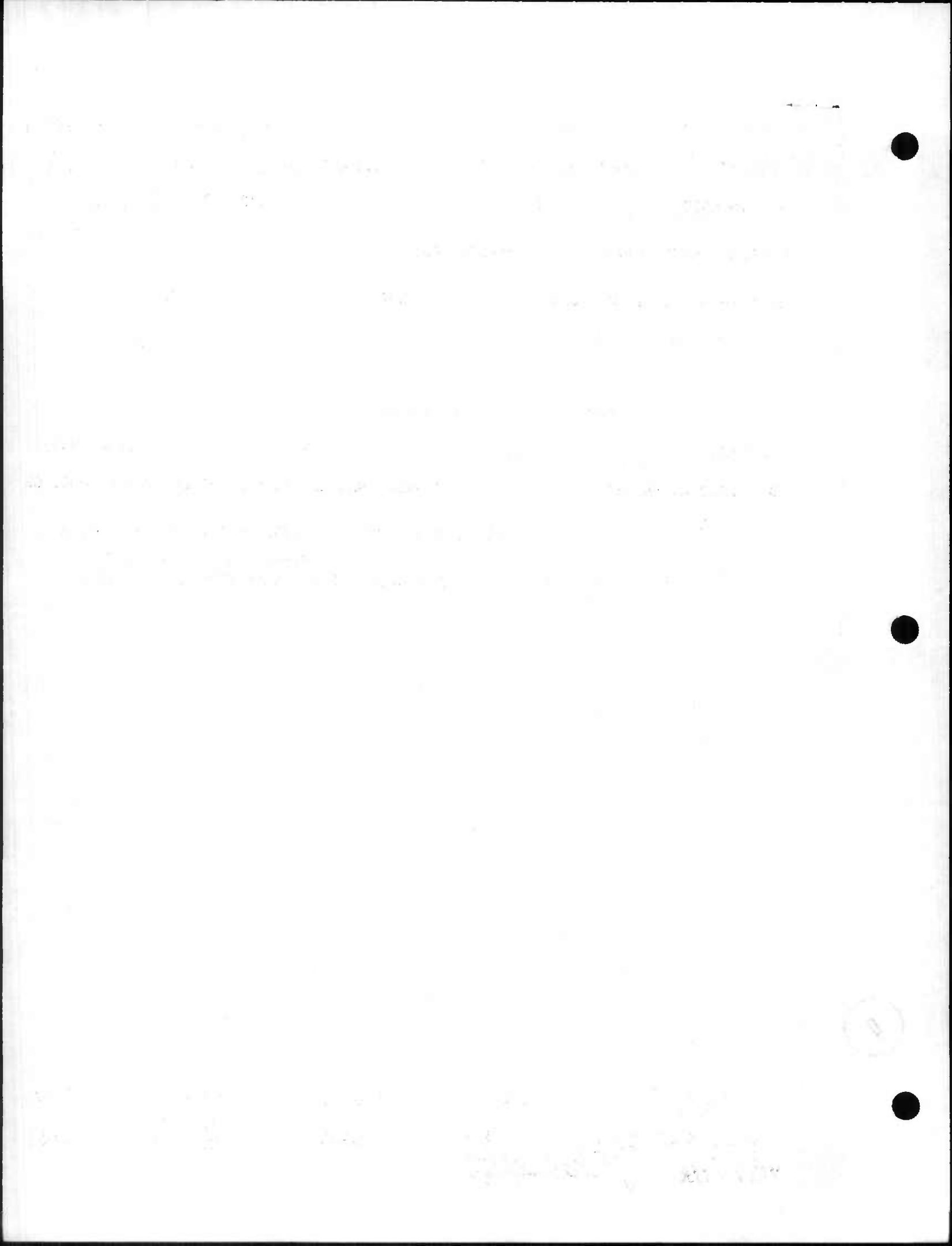
Division of Vital Records, P.O. Box 68760,

To the Registrar: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filed in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG NO

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

| | | | | | |
|--|--|--|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
CHARLES B. McCammon | | 2. DATE OF DEATH
MONTH DAY YEAR
MAY 25 1996 | | 3. TIME OF DEATH
1:05 PM | |
| 4. SOCIAL SECURITY NUMBER
212-05-2147 | | 5. SEX
1 <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
80 YRS. | |
| 7. DATE OF BIRTH (Month, Day, Year)
Feb. 01, 1916 | | 8. BIRTHPLACE (State or Foreign Country)
Maryland | | | |
| 9a. FACILITY NAME (If not institution, give street and number)
Meridian Nursing Home | | 9b. CITY, TOWN OR LOCATION OF DEATH
Catonsville | | 9c. COUNTY OF DEATH
Baltimore | |
| RESIDENCE OF DECEDENT | | | | | |
| 10a. STATE
Maryland | | 10b. COUNTY
Baltimore | | 10c. CITY, TOWN OR LOCATION
Catonsville | |
| 10d. INSIDE CITY LIMITS?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | | |
| 10e. STREET AND NUMBER
2 Bristol Hill Court Apt. 1-A | | 10f. ZIP CODE
21228 | | 10g. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 11. MARITAL STATUS
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO
IF YES, GIVE WAR OR DATES
W W II | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | |
| 14. RACE — American Indian, Black, White, etc.
Specify: White | | | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12) 12
College (1-4 or 5+) College (1-4 or 5+) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
Fire Marshall | | 16b. KIND OF BUSINESS/INDUSTRY
Joseph E. Seagram | |
| 17. FATHER'S NAME (First, Middle, Last)
Henry McCammon | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Sophia Willhauch | | | |
| 19a. INFORMANT'S NAME (Type/Print)
Margaret McCammon (Spouse) | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
2 Bristol Hill Court Catonsville, Maryland 21228 | | | |
| 20a. METHOD OF DISPOSITION
<input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
Metro Crematory May 29, 1996 | | 20c. LOCATION — City or Town, State
Catonsville, Maryland | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
 | | 22. NAME AND ADDRESS OF FACILITY
Witzke Funeral Homes, Inc.
1630 Edmondson Avenue Catonsville, Maryland | | | |
| 23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
IMMEDIATE CAUSE (Final disease or condition resulting in death) → PULMONARY EMBOLUS
DUE TO (OR AS A CONSEQUENCE OF):
STROKE
DUE TO (OR AS A CONSEQUENCE OF):
HYPERTENSIVE CARDIO VASCULAR DISEASE
DUE TO (OR AS A CONSEQUENCE OF):
Approximate Interval Between Onset and Death
24h
11wks
YEARS | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA
OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | |
| 27. MANNER OF DEATH
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation
<input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined
<input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M | |
| 28c. INJURY AT WORK?
<input type="checkbox"/> YES <input type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | | | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one)
<input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
Andrew Marks | | 29c. LICENSE NUMBER
D31205 | | 29d. DATE SIGNED (Month, Day, Year)
MAY 26 1996 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
W. ANDREW MARKS 2 KNOLL NORTH DRIVE COLUMBIA, MD 21045 | | | | | |
| 31. DATE FILED (Month, Day, Year)
MAY 28 1996 | | 32. REGISTRAR'S SIGNATURE
 | | | |

10

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 15656

Certificate of Death

Reg. No.

| | | | | | | | | |
|--|--|--|--|--|---|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
John H. Miller, Sr. | | | | 2. Date of Death
Month Day Year
May 22 1996 | | 3. Time of Death
3:00 AM | |
| | 4a. Facility Name (If not institution, give street and number)
9050 Early April Way | | | | 4b. City, Town, or Location of Death
Columbia | | 4c. County of Death
Howard | |
| Funeral
Director | 5. Social Security Number
061-18-8904 | | 6. Sex
1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | 7. Age (In yrs. last birthday)
76 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth (Month, Day, Year)
Jan. 23, 1920 | 9. Birthplace (State or Foreign Country)
NY |
| | Usual Residence of Decedent | | | | | | | |
| 10a. State
MD | | 10b. County
Howard | | 10c. City, Town or Location
Columbia | | | 10d. Inside City Limits
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | |
| 10e. Street and Number
9050 Early April Way | | | | 10f. Zip Code
21046 | | 10g. Citizen of What Country?
USA | | |
| 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No
If Yes, Give Year or Dates: WW II | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc.
Specify: White | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (1-4 or 5+) None | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Plant Foreman | | | 16b. Kind of Business/Industry
Plastic Company | |
| 17. Father's Name (First, Middle, Last)
Wilson P. Miller | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Hazel Kipp | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
Mildred Miller (Wife) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
9050 Early April Way, Columbia, MD 21046 | | | | |
| 20a. Method of Disposition
1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Metro Crematory | | Date
May 23, 1996 | | 20c. Location - City or Town, State
Catonsville, MD | | |
| 21. Signature of Funeral Service Licensee
Robert Gregory Boehm | | | | 22. Name and Address of Facility
Witzke Funeral Homes, Inc.
5555 Twin Knolls Rd. Columbia, MD 21045 | | | | |
| 23a. Part I. Enter the disease, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. RESPIRATORY FAILURE
Due to (or as a consequence of):
b. CHRONIC OBSTRUCTIVE PULMONARY DISEASE
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | | Approximate Interval Between Onset and Death
YEARS |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
PROSTATE CANCER, SUPRAVENTRICULAR
TACHYCARDIA, CONGESTIVE HEART FAILURE | | | | | | 23b. Did tobacco use contribute to the cause of death?
<input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | |
| 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | |
| 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospice: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide
5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of injury
M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred |
| 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | 29b. Signature and title of certifier
MD |
| 29c. License number
D36845 | | | | 29d. Date signed (Month, Day, Year)
May 22, 1996 | | | | |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)
MAI-CHI NGUYEN, MD
5999 HARPER FARM RD, SUITE 200-E, COLUMBIA, MD 21044 | | | | | | | | 31. Date of completion (Month, Day, Year)
MAY 28 1996 |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 15657

Certificate of Death

Reg. No.

| | | | | | | | | |
|--|---|---|--|--|--|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Pearl Marie Michaels | | | | 2. Date of Death
Month Day Year
May 24 1996 | | 3. Time of Death
10:40 AM | |
| | 4a. Facility Name (If not institution, give street and number)
Greater Baltimore Medical Center | | | | 4b. City, Town, or Location of Death
N/A | | 4c. County of Death
Baltimore | |
| Funeral
Director | 5. Social Security Number
208-22-9502 | 6. Sex
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)
68 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth (Month, Day, Year)
Aug 22, 1927 | | 9. Birthplace (State or Foreign Country)
Pennsylvania |
| | Usual Residence of Decedent | | | | | | | |
| 10a. State
Md | | 10b. County
Baltimore | | 10c. City, Town or Location
N/A | | | 10d. Inside City Limits
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | |
| 10e. Street and Number
6713 Pine Ave | | | | 10f. Zip Code
21222 | | 10g. Citizen of What Country?
USA | | |
| 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: White | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (1-4 or 5+) College | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Housewife | | 16b. Kind of Business/Industry
Own Home | | |
| 17. Father's Name (First, Middle, Last)
Bennie Rager | | | | 16. Mother's Name (First, Middle, Maiden Surname)
Kathryn Miller | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
Raymond Michaels /husband | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
6713 Pine Ave Baltimore, Md 21222 | | | | |
| 20a. Method of Disposition
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Holly Hill | | Date
5/28/96 | | 20c. Location - City or Town, State
Baltimore, Md | | |
| 21. Signature of Funeral Service Licensee
<i>Anthony Colt Connelly</i> | | | | 22. Name and Address of Facility
Connelly Funeral Home of Dundalk
7110 Sollers Point Rd 21222 | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
e. Cardiorespiratory arrest
Due to (or as a consequence of):
CVA
b. Cerebral atherosclerosis
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.
Approximate interval between Onset and Death
minutes
2 days | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Hypertension | | | | | | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown | | |
| | | | | | | 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |
| 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide
5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred |
| | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | |
| 29a. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier
<i>MP</i> | | | | | | |
| | | 29c. License number
D4723 | | 29d. Date signed (Month, Day, Year)
5/25/96 | | | | |
| 30. Name and address of person who completed cause of death (item 23a) (Type, Print)
M. Piper, M.D. 7141 Security Blvd Baltimore, Md 21244 | | | | | | | | |
| 31. Date filed (Month, Day, Year)
MAY 28 1996 | | 32. Registrar's Signature
<i>Julia Davidson-Randall</i> | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

96 15658

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|---|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
Ronald A. Numbers | | | | 2. DATE OF DEATH
MONTH DAY YEAR
May 27 1996 | | 3. TIME OF DEATH
12:07 P.M. | |
| 4. SOCIAL SECURITY NUMBER
219 26 5509 | | 5. SEX
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
57 YRS. | | 7. DATE OF BIRTH
(Month, Day, Year)
April 22, 1939 | |
| 8. BIRTHPLACE (State or Foreign Country)
Maryland | | | | 9. CITY, TOWN OR LOCATION OF DEATH
Baltimore City | | | |
| 10. COUNTY OF DEATH
n/a | | | | 11. FACILITY NAME (If not institution, give street and number)
Union Memorial Hospital | | | |
| 10a. STATE
Maryland | | 10b. COUNTY
Anne Arundel | | 10c. CITY, TOWN OR LOCATION
Glen Burnie | | 10d. INSIDE CITY LIMITS?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 10e. STREET AND NUMBER
7140 Baltimore and Annapolis Blvd. | | | | 10f. ZIP CODE
21061 | | 10g. CITIZEN OF WHAT COUNTRY?
United States | |
| 11. MARITAL STATUS
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO
IF YES, GIVE WAR OR DATES
Vietnam Era | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify: White | |
| 15. DECEDENT'S EDUCATION
(Specify only highest grade completed)
12 | | 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.)
Soldier | | 16b. KIND OF BUSINESS/INDUSTRY
Military U.S. Government | | | |
| 17. FATHER'S NAME (First, Middle, Last)
Marion E. Numbers | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Mildred Anderson | | | |
| 19a. INFORMANT'S NAME (Type/Print)
Judith A. Numbers / wife | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
7140 Balt. & Annap. Blvd., Glen Burnie, MD 21061 | | | |
| 20a. METHOD OF DISPOSITION
<input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
Green Mount Crematory 5/28/96 | | 20c. LOCATION — City or Town, State
Baltimore, MD | | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
Stephen D. Lohrmann | |
| 22. NAME AND ADDRESS OF FACILITY
CAFA Stephen D. Lohrmann P.A.
8717 Green Pastures Dr., Baltimore, MD 21286 | | 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

IMMEDIATE CAUSE (Final disease or condition resulting in death) → Hypoxic Encephalopathy
DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST
Respiratory arrest
DUE TO (OR AS A CONSEQUENCE OF):
Severe COPD
DUE TO (OR AS A CONSEQUENCE OF):

Approximate Interval Between Onset and Death
5 days
5 days
15 YR | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | 24a. WAS AN AUTOPSY PERFORMED?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA
OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | |
| 27. MANNER OF DEATH
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M | | 28c. INJURY AT WORK?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one)
<input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
Robert McKinney, D.O. | | | | 29c. LICENSE NUMBER
AT2438946 | | 29d. DATE SIGNED (Month, Day, Year)
5-27-96 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
Robert McKinney, D.O., UMH 2-1 E. Univ. Pkwy, Balt., MD 21208 | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
MAY 28 1996 | | 32. REGISTRAR'S SIGNATURE
Julia Davidson-Randall | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 2-3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

6+1

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 15659

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Ernestine, Neal

2. Date of Death

Month Day Year
05 25 96

3. Time of Death

7 20

4a. Facility Name (If not institution, give street and number)

UNIVERSITY OF MARYLAND

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

n/a

Funeral
Director

5. Social Security Number

216-90-5399

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

31 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Dec. 8, 1964

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

MD

10b. County

n/a

10c. City, Town or Location

Baltimore

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

912 N. Freemont Ave.

10f. Zip Code

21217

10g. Citizen of What Country?

USA

11. Marital Status

1 ☒ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
12th

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Waitress

16b. Kind of Business/Industry

Restaurant

17. Father's Name (First, Middle, Last)

Robert P. Neal

18. Mother's Name (First, Middle, Maiden Surname)

Annie Williamson

19a. Informant's Name/Relationship (Type, Print)

Robert Neal

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

912 N. Fremont Ave. BALto., MD 21217

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Western Star

Date

5/29

20c. Location - City or Town, State

Baltimore, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

James A. Morton & Sons Funeral Homes
1701 Laurens St. Balto., MD 21217

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. PCP Pneumonia (Pneumocystis Carinii Pneumonia)

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. AIDS (Acquired Immune Deficiency Syndrome)

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

P 09765

29d. Date signed (Month, Day, Year)

May, 25, 1996

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SYDILLE WOEL MD 22 SOUTH GREEN ST. BALTIMORE MD 21201

31. Date filed (Month, Day, Year)

MAY 28 1996

32. Registrar's Signature

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

State
Registrar

ITEM: 1. & 4c, PER F.H. FILM
G-735 5/28/96 t.t

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 15660

Certificate of Death

Reg. No.

| | | | | | | | | | | | |
|---|---|---|--|--|--|--|--|--|---|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
<u>Warren Perry</u> WARREN H. PERRY | | | | 2. Date of Death
Month <u>5</u> Day <u>24</u> Year <u>96</u> | | 3. Time of Death
<u>8:35 pm</u> | | | | |
| | 4a. Facility Name (If not institution, give street and number)
<u>Johns Hopkins Bayview Medical Center</u> | | | | 4b. City, Town, or Location of Death
<u>Baltimore</u> | | 4c. County of Death
<u>Baltimore</u> N/A | | | | |
| Funeral
Director | 5. Social Security Number
<u>218-09-3609</u> | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)
<u>75</u> Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth (Month, Day, Year)
<u>September 2, 1921</u> | | 9. Birthplace (State or Foreign Country)
<u>Maryland</u> | | |
| | Usual Residence of Decedent | | | | | | | | | | |
| To Be Completed by Funeral Director | 10e. State
<u>Maryland</u> | | 10b. County
<u>N/A</u> | | 10c. City, Town or Location
<u>Baltimore</u> | | | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | |
| | 10e. Street and Number
<u>3805 Ravenwood Avenue</u> | | | | 10f. Zip Code
<u>21213</u> | | 10g. Citizen of What Country?
<u>United States</u> | | | | |
| | 11. Marital Status
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
If Yes, Give Year or Dates: <u>1942-1945</u> | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc.
Specify: <u>White</u> | | | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) <u>12</u> College (1-4or 5+) <u>2</u> | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
<u>Mail Carrier</u> | | | 16b. Kind of Business/Industry
<u>U.S. Government</u> | | | | | |
| To Be Completed by Physician/Medical Examiner | 17. Father's Name (First, Middle, Last)
<u>Frank Perry</u> | | | | 18. Mother's Name (First, Middle, Maiden Surname)
<u>Leanore Vito</u> | | | | | | |
| | 19e. Informant's Name/Relationship (Type, Print)
<u>Mary S. Perry/ Wife</u> | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
<u>3805 Ravenwood Avenue Baltimore, Maryland 21213</u> | | | | | | |
| | 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
<u>Parkwood Cemetery</u> | | Data
<u>5/28/96</u> | | 20c. Location - City or Town, State
<u>Baltimore, Maryland</u> | | | | |
| | 21. Signature of Funeral Service Licensee
<u>Brian A. Willem</u> | | | | 22. Name and Address of Facility
<u>Leonard J. Ruck Funeral Home, Inc.
5305 Harford Road Baltimore, Maryland 21214</u> | | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
<u>a. Ventricular fibrillation arrest</u>
Due to (or as a consequence of):
<u>b. Ruptured aortic Aneurysm</u>
Due to (or as a consequence of):
<u>c.</u>
Due to (or as a consequence of):
<u>d.</u>

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | | | | Approximate Interval Between Onset and Death
<u>10 min</u>
<u>11 hours</u> | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
<u>none</u> | | | | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | | | |
| | | | | | | | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
<u>M</u> | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input type="checkbox"/> No | | 28d. Describe how Injury occurred | | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier
<u>[Signature]</u> | | 29c. License number
<u>12988</u> | | 29d. Date signed (Month, Day, Year)
<u>5/24/96 (MAY)</u> | | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
<u>Th. Genuit MD Johns Hopkins Bayview Medical Center, Baltimore</u> | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
<u>MAY 28 1996</u> | | 32. Registrar's Signature
<u>John Davidson-Randall</u>
<u>6 + 1</u> | | | | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

to the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 15661

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

MILDRED PLATT

2. Date of Death

Month Day Year
MAY 24 1996

3. Time of Death

1:20 AM

4a. Facility Name (If not institution, give street and number)

LEVINDALE

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

N/A

Funeral
Director

5. Social Security Number

216-01-9754

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

82 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
OCT. 21, 1913

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MD

10b. County

BALTIMORE

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

6604 COPPER RIDGE DR., APT. 102

10f. Zip Code

21209

10g. Citizen of What Country?

USA

11. Marital Status

1 ☒ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

Collage (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

OFFICE MANAGER

16b. Kind of Business/Industry

DAVID PLATT & CO., INC.

17. Father's Name (First, Middle, Last)

LOUIS

A

PLATT

18. Mother's Name (First, Middle, Maiden Summa)

IDA

S

RADESKY

19a. Informant's Name/Relationship (Type, Print)

IRVIN PLATT (BRO.)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

6604 COPPER RIDGE DR., APT. 102 BALTO., MD 21209

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

HEBREW FRIENDSHIP

Date

5/26/96

20c. Location - City or Town, State

BALTIMORE, MD

21. Signature of Funeral Service Licensee

Michael S. Saper

22. Name and address of facility

SOL LEVINSON & BROS., INC.
8900 REISTERSTOWN RD., PIKEVILLE, MD 21208

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. LYMPHOMA OF CENTRAL NERVOUS SYSTEM

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☒ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Sege Ewin ATTENDING PHYSICIAN

29c. License number

D25610

29d. Date signed (Month, Day, Year)

MAY 24 1996

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

LEVINDALE 2434 W. BELVERDERE AVENUE BALTIMORE MD 21215

31. Date filed (Month, Day, Year)

MAY 28 1996

32. Registrar's Signature

Julia Davidson-Randall

State Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Baltimore, Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 23b are marked other than any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Certificate of Death

Reg. No.

| | | | | | | | | |
|--|--|--|---------------------------------|---|---|---|---|---|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
STEWART PATTERSON | | | | 2. Date of Death
Month MAY Day 23 Year 1996 | | 3. Time of Death
12:05AM | |
| | 4a. Facility Name (If not institution, give street and number)
CHURCH HOME & HOSP. 100 N. BROADWAY | | | | 4b. City, Town, or Location of Death
BALT. MD | | 4c. County of Death
N/A | |
| Funeral
Director | 5. Social Security Number
243-42-8903 | | 6. Sex
1 M 2 F | 7. Age (In yrs. last birthday)
63 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth (Month, Day, Year)
1/28/33 | 9. Birthplace (State or Foreign)
LITTLETON, N.C. |
| | Usual Residence of Decedent | | | | | | | |
| 10a. State
MD | | 10b. County
N/A | | 10c. City, Town or Location
BALTIMORE | | | 10d. Inside City Limits
1 Yes 2 No | |
| 10e. Street and Number
1510 E. FEDERAL ST. | | | | 10f. Zip Code
21213 | | 10g. Citizen of What Country?
USA | | |
| 11. Marital Status
1 Never Married 2 Married
3 Widowed 4 Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No
If Yes, Give Year or Dates: 1953-1955 | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 Yes 2 No Specify: | | | 14. Race - American Indian, Black, White, etc.
Specify: BLACK | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12th College (1-4or 5+) - | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Laborer | | | 16b. Kind of Business/Industry
Bethlehem Steel | |
| 17. Father's Name (First, Middle, Last)
William Patterson | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Annie Smith | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
Ella Mae Patterson | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1447 Montpelier Street, Baltimore, MD 21218 | | | | |
| 20a. Method of Disposition
1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Garrison Forest VA Cem. 5-28-96 | | Date | | 20c. Location - City or Town, State
Owings Mills, MD | | |
| 21. Signature of Funeral Service Licensee
<i>Agnetta K. Jones</i> | | | | 22. Name and Address of Facility
March Funeral Home
1101 E. North Avenue, Baltimore, MD 21202 | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. Pancreatic Cancer
Due to (or as a consequence of):

b.
Due to (or as a consequence of):

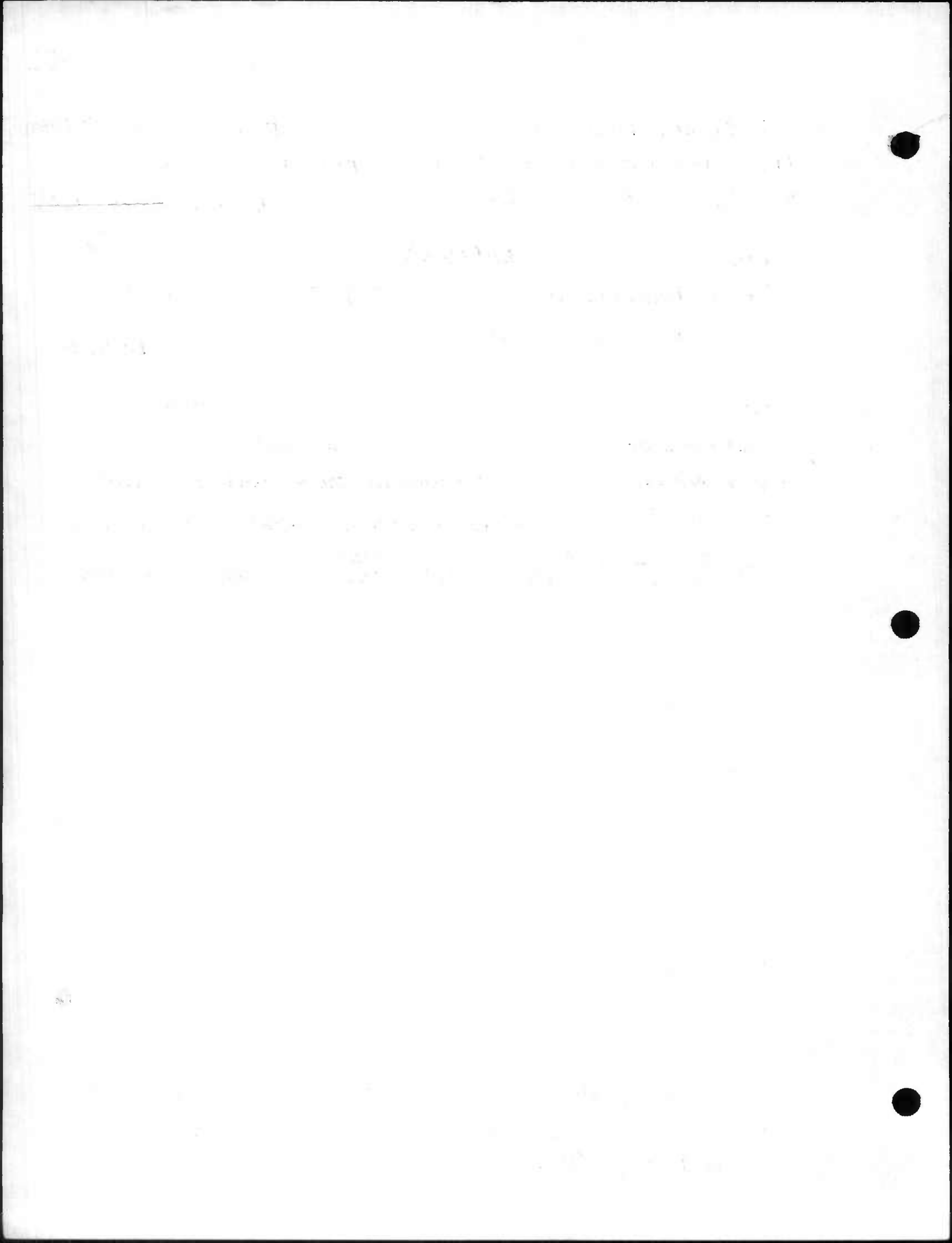
c.
Due to (or as a consequence of):

d.
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | | Approximate Interval Between Onset and Death
2 months |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death?
1 Yes 2 No 3 Probably 4 Unknown | | |
| | | | | | | 24a. Was an autopsy performed?
1 Yes 2 No | | |
| | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
1 Yes 2 No | | |
| 25. Was case referred to medical examiner?
1 Yes 2 No | | 26. Place of Death (Check only one)
Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) | | | | | | |
| 27. Manner of Death
1 Natural 5 Pending investigation
2 Accident 6 Could not be determined
3 Suicide 4 Homicide | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
1 Yes 2 No | | 28d. Describe how injury occurred |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | |
| 29a. Certifier (Check only one)
1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | |
| 29b. Signature and title of certifier
<i>Dr. Ochaney</i> | | | | 29c. License number
D-40521 | | 29d. Date signed (Month, Day, Year)
May 23, 1996 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
DR. OCHANAY 100 N BROADWAY BALTIMORE, MD 21231 | | | | | | | | |
| 31. Date filed (Month, Day, Year)
MAY 28 1996 | | 32. Registrar's Signature
<i>John Davidson-Randall</i> | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

5+1



96 15663

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
<i>Mary Louise Pierce</i> | | | | 2. DATE OF DEATH
MONTH DAY YEAR
<i>MAY 22 96</i> | | 3. TIME OF DEATH
<i>2:55 A M</i> | |
| 4. SOCIAL SECURITY NUMBER
<i>220-14-6782</i> | | 5. SEX
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 6. AGE (In yrs. last birthday)
<i>73</i> YRS. | 7. DATE OF BIRTH (Month, Day, Year)
<i>Dec. 23, 1922</i> | | 8. BIRTHPLACE (State or Foreign Country)
<i>Virginia</i> | |
| 9a. FACILITY NAME (If not institution, give street and number)
<i>Union Memorial Hospital</i> | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
<i>Baltimore City</i> | | 9c. COUNTY OF DEATH
<i>N/A</i> | |
| 10a. STATE
<i>Maryland</i> | | 10b. COUNTY
<i>N/A</i> | | 10c. CITY, TOWN OR LOCATION
<i>Baltimore</i> | | 10d. INSIDE CITY LIMITS?
1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER
<i>521 E. 38th Street</i> | | | | 10f. ZIP CODE
<i>21218</i> | | 10g. CITIZEN OF WHAT COUNTRY?
<i>United States</i> | |
| 11. MARITAL STATUS
1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify:
<i>Black</i> | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)
<i>11th</i> | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
<i>Housekeeping</i> | | 16b. KIND OF BUSINESS/INDUSTRY
<i>Hospital</i> | | | |
| 17. FATHER'S NAME (First, Middle, Last)
<i>Hubert Burns</i> | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
<i>Alberta Chambers</i> | | | |
| 19a. INFORMANT'S NAME (Type/Print)
<i>Rene' Pierce</i> | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
<i>4216 Loch Raven Blvd. Apt. 443, Balto., MD 21218</i> | | | |
| 20a. METHOD OF DISPOSITION
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
<i>Voshell Memorial Gardens 5-28 Dundalk, MD</i> | | 20c. LOCATION — City or Town, State | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
<i>[Signature]</i> | | | | 22. NAME AND ADDRESS OF FACILITY
<i>March Funeral Home
1101 E. North Avenue, Baltimore, MD 21202</i> | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Acute Exacerbation of Bronchitis</i> | | | | | | | |
| DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | |
| b. <i>Chronic Obstructive Pulmonary Disease</i> | | | | | | | |
| DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| c. <i>Congestive Heart Failure</i> | | | | | | | |
| DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| d. | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
<i>Hypertension</i> | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA
OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation
2 <input type="checkbox"/> Accident
3 <input type="checkbox"/> Suicide 6 <input type="checkbox"/> Could not be determined
4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
<i>M</i> | | 28c. INJURY AT WORK?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| | | 28d. DESCRIBE HOW INJURY OCCURED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. CERTIFIER (Check only one)
1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
<i>Aruna Nathan M.D.</i> | | | | 29c. LICENSE NUMBER
<i>AT 2438946</i> | | 29d. DATE SIGNED (Month, Day, Year)
<i>MAY 22, 96</i> | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
<i>Aruna Nathan, Union Memorial Hospital MD</i> | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
<i>MAY 28 1996</i> | | 32. REGISTRAR'S SIGNATURE
<i>[Signature]</i> | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Anne Davidson Root

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 15664

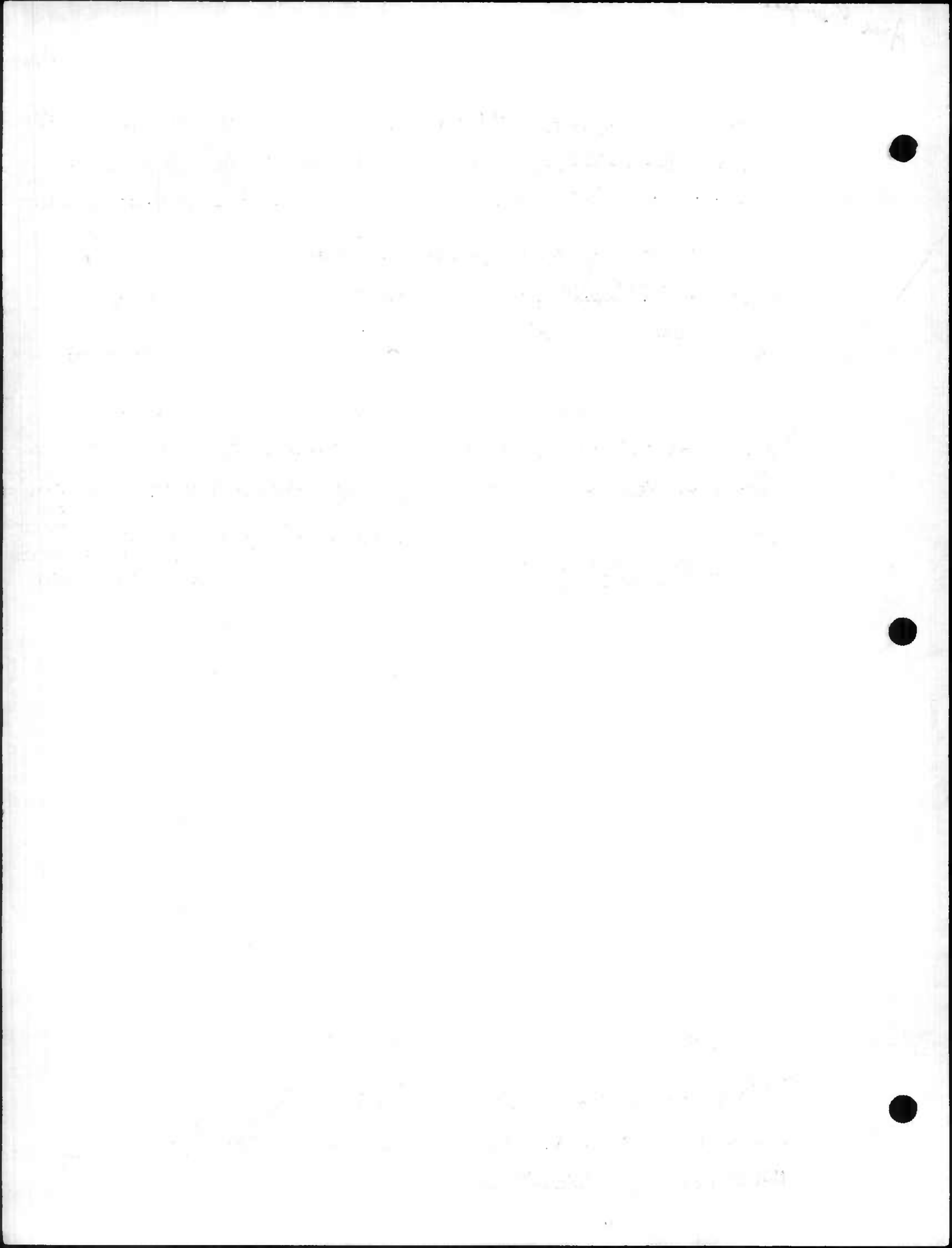
Certificate of Death

Reg. No.

| | | | | | | | | | |
|--|--|---|---|--|--|--|--|---|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
ANNE DAVIDSON ROOT PRANGE | | | | 2. Date of Death
Month 5 Day 17 Year 96 | | 3. Time of Death
3:00 PM | | |
| | 4a. Facility Name (If not institution, give street and number)
4307 SHERIDAN ST | | | | 4b. City, Town, or Location of Death
University Park | | 4c. County of Death
Prince Georges | | |
| Funeral
Director | 5. Social Security Number
319-05-4072 | | 6. Sex
1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | Age (In yrs. last birthday)
82 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth
(Month, Day, Year)
5-31-13 | 9. Birthplace (State or Foreign Country)
MADISON, WI | |
| | Usual Residence of Decedent | | | | | | | | |
| To Be Completed by Funeral Director | 10a. State
MD | 10b. County
PRINCE GEORGES | 10c. City, Town or Location
University Park | | | | 10d. Inside City Limits
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | |
| | 10e. Street and Number
4307 SHERIDAN ST | | 10f. Zip Code
20782 | | 10g. Citizen of What Country?
USA | | | | |
| | 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married
3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: WHITE | | |
| | 15. Decedent's Education
(Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (14 or 5+) BA MA | | 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)
HOMEMAKER | | 16b. Kind of Business/Industry
NA | | | | |
| | 17. Father's Name (First, Middle, Last)
WINFRED TREXLER ROOT | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Anne Davidson Harper | | | | |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print)
WINFRED TREXLER ROOT PRANGE/Son | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
4249 HERMITAGE DR CITY, MD 21042 | | | | |
| | 20a. Method of Disposition
1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input checked="" type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
U MD; Anatomy Bldg | | 20c. Location - City or Town, State
Baltimore ST B-026 BALT. MD, 21201 | | 20d. Date
5/17/96 | | |
| | 21. Signature of Funeral Service Licensee
Ronald S. Wade, Dir. | | | | 22. Name and Address of Facility | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
Immediate Cause (Final disease or condition resulting in death)
a. hepatic failure
Due to (or as a consequence of):
b. metastatic cancer of breast
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.
Approximate interval Between Onset and Death
4 mos
6 years | | | | | | | | |
| | 23b. Part II. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | |
| | | | | | | 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | |
| | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | |
| 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide
5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 26a. Date of injury (Month, Day, Year) | | 26b. Time of injury
M | | 26c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26d. Describe how injury occurred | |
| | | 26e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 26f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| 29a. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier
MARTIN D. WELTZ | | | | | | | |
| | | 29c. License number
D23743 | | 29d. Date signed (Month, Day, Year)
5-17-96 | | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
MARTIN D. WELTZ 7525 Greenway Ct On Greenbelt MD 20770 | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
MAY 28 1996 | | 32. Registrar's Signature
A. Davidson-Rendall | | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 15665

Certificate of Death

Reg. No.

| | | | | | | | | | | | | | | |
|---|---|---------------------------|---|---|---|--|--------------------------------|--|---|--|--|--|---|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
WILLIAM L. POWELL | | | | 2. Date of Death
Month MAY Day 24 Year 1996 | | | | 3. Time of Death
6:10 A.M. | | | | | |
| | 4a. Facility Name (If not Institution, give street and number)
2105 CRIMEA ROAD | | | | 4b. City, Town, or Location of Death
BALTIMORE | | | | 4c. County of Death
N/A | | | | | |
| Funeral
Director | 5. Social Security Number
231 01 9064 | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday)
78 Yrs. | | If Under 1 Year
Months Days | | If Under 24 Hrs.
Hours Min. | | 6. Date of Birth (Month, Day, Year)
JAN. 4, 1918 | | 9. Birthplace (State or Foreign Country)
VIRGINIA | |
| | Usual Residence of Decedent | | | | | | | | | | | | | |
| 10a. State
MD. | | 10b. County
N/A | | 10c. City, Town or Location
BALTIMORE | | | | | | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | |
| 10e. Street and Number
2105 CRIMEA ROAD | | | | 10f. Zip Code
21207 | | | | 10g. Citizen of What Country?
U.S. OF A. | | | | | | |
| 11. Marital Status
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced | | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc.
Specify: BLACK | | | | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 10TH College (1-4 or 5+) NONE | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
T.V. PROP MAN | | | | 16b. Kind of Business/Industry
TELEVISION | | | | | | |
| 17. Father's Name (First, Middle, Last)
BENNIE POWELL | | | | | | 18. Mother's Name (First, Middle, Maiden Surname)
RANNIE HAWKINS | | | | | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
MRS. AVIS A., UMSTEAD(NIECE) | | | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
3519 WOODGATE COURT ELLICOTT CITY, MD. 21042 | | | | | | | | |
| 20a. Method of Disposition
<input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
METRO CREMATORY MAY 27, 1996 | | | | 20c. Location - City or Town, State
CATONSVILLE, MD.CO. BALTO | | | | | | |
| 21. Signature of Funeral Service Licensee
 LEWIS T. GWYNN | | | | | | 22. Name and Address of Facility
LEWIS T. GWYNN FUNERAL HOME 21215 4517 PARK HEIGHTS AVE. BALTO, MD. | | | | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. metastatic prostate cancer
Due to (or as a consequence of):
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.
Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last | | | | | | | | | | | | Approximate Interval Between Onset and Death
2 years | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | |
| | | | | | | | | | | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input type="checkbox"/> No | | 28d. Describe how injury occurred | | | | |
| | | | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | | | | | | | |
| 29b. Signature and title of certifier
 M.D. | | | | | | 29c. License number
D40850 | | 29d. Date signed (Month, Day, Year)
May 27, 1996 | | | | | | |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)
YVONNE OTTAVIANO M.D. 900 CATON AVE BALTIMORE MD 21229 | | | | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
MAY 28 1996 | | | | 32. Registrar's Signature
 | | | | | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 15666

Certificate of Death

Reg. No.

| | | | | | | | | |
|--|--|---|--|--|--|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
OLGA ETHEL PERRONE | | | | 2. Date of Death
Month Day Year
May 18 1996 | | 3. Time of Death
9:55p | |
| | 4a. Facility Name (If not institution, give street and number)
THE MEMORIAL HOSPITAL AT EASTON | | | | 4b. City, Town, or Location of Death
EASTON | | 4c. County of Death
TALBOT | |
| Funeral
Director | 5. Social Security Number
138-18-6634 | | 6. Sex
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday)
73 Yrs. | | 8. Date of Birth (Month, Day, Year)
JUN. 23, 1922 N. BRUNSWICK | |
| | 10a. State
OH | | 10b. County
MEDINA | | 10c. City, Town or Location
NADSWORTH | | 10d. Inside City Limits
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| 10e. Street and Number
190 MAIN ST. APT. 213 | | 10f. Zip Code
44281 | | 10g. Citizen of What Country?
U.S.A. | | | | |
| 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: WHITE | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 11 Collega (1-4or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
FOREMAN | | 16b. Kind of Business/Industry
PHARMACEUTICAL | | | | |
| 17. Father's Name (First, Middle, Last)
JOSEPH FEKETE | | | | 18. Mother's Name (First, Middle, Maiden Summa)
ROSE MARKOWITZ | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
BEV SCHAFFER | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
3433 BLAKE RD. SEVILLE, OH. 44713 | | | | |
| 20a. Method of Disposition
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
WOODLAWN CEM. 5-22-96 NADFWORTH, OH. | | 20c. Location - City or Town, State | | | | |
| 21. Signature of Funeral Service Licensee
<i>Phonny J. Shuck Jr.</i> | | | | 22. Name and Address of Facility
SKARDA F.H. 2829 HUDSON ST. BALTO., MD. 21224 | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. Intracerebral hemorrhage
Dua to (or as a consequence of):

b.
Dua to (or as a consequence of):

c.
Dua to (or as a consequence of):

d.
Dua to (or as a consequence of):

Sequitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last | | | | | | | | Approximate Interval Between Onset and Death
4 days |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Diabetes | | | | | | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown | | |
| | | | | | | 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |
| 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 28. Place of Death (Check only one)
Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation
2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined
3 <input type="checkbox"/> Suicida 4 <input type="checkbox"/> Homicida | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how Injury occurred |
| | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | |
| 29a. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier
<i>md</i> | | 29c. License number
044749 | | 29d. Date signed (Month, Day, Year)
5/19/96 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
PETER L. WHITESELL 609 DUTCHMANS LANE EASTON, MD. 21601 | | | | | | | | |
| 31. Date filed (Month, Day, Year)
MAY 28 1996 | | 32. Registrar's Signature
<i>J. L. Wilson</i> | | | | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

to the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 15667

Certificate of Death

Reg. No.

| | | | | | | | | |
|--|---|--|---|-----------------------------------|--|---|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
MARY A. PEPLINSKI | | | | 2. Date of Death
Month Day Year
MAY 23 1996 | | 3. Time of Death
11:30 AM | |
| | 4a. Facility Name (If not institution, give street and number)
8403 Mt. Airy Ct | | | | 4b. City, Town, or Location of Death
ROSEDALE | | 4c. County of Death
BALTIMORE | |
| Funeral
Director | 5. Social Security Number
198284666 | | 6. Sex
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday)
60 Yrs. | | 8. Date of Birth (Month, Day, Year)
April 14, 1936 | |
| | 9. Birthplace (State or Foreign Country)
CZECHOSLOVAKIA | | 10a. State
MD | | 10b. County
BALTIMORE | | 10c. City, Town or Location
ROSEDALE | |
| To Be Completed by Funeral Director | 10d. Inside City Limits
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 10e. Street and Number
8403 MOUNT AIRY COURT | | 10f. Zip Code
21237 | | 10g. Citizen of What Country?
USA | |
| | 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever In U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: WHITE | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (1-4 or 5+) 1 | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
HOMEMAKER | | 16b. Kind of Business/Industry
OWN HOME | | | |
| | 17. Father's Name (First, Middle, Last)
ANDREW PILLAR | | | | 18. Mother's Name (First, Middle, Maiden Surname)
AGNES CMAR | | | |
| | 19a. Informant's Name/Relationship (Type, Print)
JOHN PEPLINSKI /HUSBAND | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
8403 MOUNT AIRY CT. ROSEDALE, MD 21237 | | | |
| | 20a. Method of Disposition
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
GARDENS OF FAITH | | 20c. Location - City or Town, State
5/28/96 BALTIMORE, MD | | | |
| | 21. Signature of Funeral Service Licensee
Dennis S. Kelly | | | | 22. Name and Address of Facility
CVACH/ROSEDALE FUNERAL HOME
1211 CHESACO AVE 21237 | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

<div style="display: flex; justify-content: space-between;"> <div> <p>Immediate Cause (Final disease or condition resulting in death)</p> <p>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last</p> </div> <div> <p>a. CARDIAC ARREST</p> <p>b. HYPERTENSION</p> <p>c. DIABETES MELLITUS</p> <p>d. CHRONIC RENAL FAILURE</p> </div> <div> <p>Approximate Interval Between Onset and Death</p> <p>several years</p> <p>several years</p> <p>several years</p> </div> </div> | | | | | | | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Hypothyroidism | | | | | | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | |
| | | | | | | | 24e. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | |
| | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | |
| 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide
5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | |
| | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28d. Describe how Injury occurred | | | | |
| 29a. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier
Saba Siddiqi physician | | 29c. License number
D41496 | | 29d. Date signed (Month, Day, Year)
5/23/96 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
SABA SIDDIQI 405 Stemmers Run Road Balto MD 21221 | | | | | | | | |
| 31. Date filed (Month, Day, Year)
MAY 28 1996 | | 32. Registrar's Signature
John Davidson | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State Registrar

ITEM: 1. PER F.H. FILM G-735
5/28/96 t.t

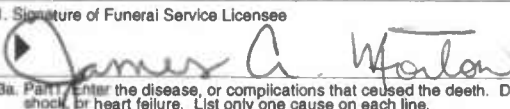
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 15668

Certificate of Death

Reg. No.

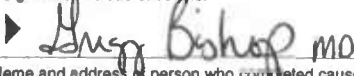
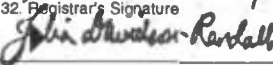
| | | | | | | | | | | |
|---|---|---------------------------------------|--|--|---|--|---|---|---|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
REED, BEVERLY BEVERLY REED | | | | 2. Date of Death
Month Day Year
MAY 25 96 | | 3. Time of Death
2:45pm | | | |
| | 4a. Facility Name (If not institution, give street and number)
UNIVERSITY OF MARYLAND HOSPITAL | | | | 4b. City, Town, or Location of Death
BALTIMORE | | 4c. County of Death
BALTIMORE | | | |
| Funeral
Director | 5. Social Security Number
212-58-7266 | | 6. Sex
1 M 2 F | 7. Age (In yrs. last birthday)
43 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth (Month, Day, Year)
Jan. 25, 1953 | | | |
| | 9. Birthplace (State or Foreign Country)
MD | | | | | | | | | |
| To Be Completed by Funeral Director | 10a. State
MD | | 10b. County
n/a | | 10c. City, Town or Location
Baltimore | | | 10d. Inside City Limits
1 Yes 2 No | | |
| | 10e. Street and Number
1924 Division St. | | | | 10f. Zip Code
21217 | | 10g. Citizen of What Country?
USA | | | |
| | 11. Marital Status
1 Never Married 2 Married
3 Widowed 4 Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 Yes 2 No Specify: | | | 14. Race - American Indian, Black, White, etc.
Specify: Black | | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12th College (1-4or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Seamstress | | | 16b. Kind of Business/Industry
Clothing | | |
| | 17. Father's Name (First, Middle, Last)
Herman Blue | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Phyllis R. Alcorn | | | | | |
| | 19a. Informant's Name/Relationship (Type, Print)
Archie Reed | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1924 Division St. Balto., MD 21217 | | | | | |
| | 20a. Method of Disposition
1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Western Star | | Date
6/1 | | 20c. Location - City or Town, State
Baltimore, MD | | | |
| | 21. Signature of Funeral Service Licensee
 | | | | 22. Name and Address of Facility
James A. Morton & Sons Funeral Home
1701 Laurens St. Balto., MD 21217 | | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. CORONARY ARTERY DISEASE
Due to (or as a consequence of):

b. _____
Due to (or as a consequence of):

c. _____
Due to (or as a consequence of):

d. _____

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last | | | | | | | | Approximate Interval Between Onset and Death
YEARS. | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | 23b. Did tobacco use contribute to the cause of death?
1 Yes 2 No 3 Probably 4 Unknown | |
| | | | | | | | | 24a. Was an autopsy performed?
1 Yes 2 No | | |
| | | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
1 Yes 2 No | | |
| 25. Was case referred to medical examiner?
1 Yes 2 No | | | | 26. Place of Death (Check only one)
Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) | | | | | | |
| 27. Manner of Death
1 Natural 5 Pending Investigation
2 Accident 6 Could not be determined
3 Suicide 4 Homicide | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
1 Yes 2 No | | 28d. Describe how injury occurred | | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | |
| 29a. Certifier (Check only one)
1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | 29b. Signature and title of certifier
 | | | | 29c. License number
P08655 | | |
| | | | | 29d. Date signed (Month, Day, Year)
5/25/96 | | | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
225 Greene St., University of Maryland Hospital, Baltimore Md. | | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
MAY 28 1996 | | | | 32. Registrar's Signature
 | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 15669

Certificate of Death

Reg. No.

| | | | | | | | | |
|--|---|---|---|--|---|--|--|---|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Catherine Siena Renshaw | | | | 2. Date of Death
Month MAY Day 23 Year 1996 | | 3. Time of Death
5:35 PM | |
| | 4a. Facility Name (If not institution, give street and number)
234 Aster Lane | | | | 4b. City, Town, or Location of Death
Forest Hill | | 4c. County of Death
Harford | |
| Funeral
Director | 5. Social Security Number
150-10-0346 | | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)
85 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth (Month, Day, Year)
FEB 17, 1911 | 9. Birthplace (State or Foreign Country)
New Jersey |
| | Usual Residence of Decedent | | | | 10a. State
Maryland | | 10b. County
Harford | |
| To Be Completed by Funeral Director | 10c. City, Town or Location
Forest Hill | | | | 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 10e. Street and Number
234 Aster Lane | |
| | 10f. Zip Code
21050 | | | | 10g. Citizen of What Country?
USA | | 11. Marital Status
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | |
| | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: White | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 Collegia (1-4or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Homemaker | | 16b. Kind of Business/Industry
Own Home | |
| | 17. Father's Name (First, Middle, Last)
Michael Patrick Ryan | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Mary Ellen Riley | | | |
| | 19a. Informant's Name/Relationship (Type, Print)
Nancy R. Magness/Daughter | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
234 Aster Lane Forest Hill, MD 21050 | | | |
| | 20a. Method of Disposition
<input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Metro Crematory, Inc. 5/24/96 | | 20c. Location - City or Town, State
Baltimore, MD | | 21. Signature of Funeral Service Licensee

George E. MacNabb | |
| | 22. Name and Address of Facility
Cremation Society of Maryland, Inc.
299 Frederick Rd. Baltimore, MD 21228 | | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

SQUAMOUS CELL CARCINOMA
Dua to (or as a consequence of):

3 YEARS | | Approximate interval Between Onset and Death | | 23b. Did tobacco use contribute to the cause of death?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | |
| | 23c. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
CARCINOMA OF BREAST
ISCHEMIC HEART DISEASE | | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No | | 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | |
| 28c. Injury at Work?
<input type="checkbox"/> Yes <input type="checkbox"/> No | | 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier

Andrew Nowakowski MD | | 29c. License number
D08096 | | 29d. Date signed (Month, Day, Year)
MAY 24, 1996 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
ANDREW NOWAKOWSKI MD 125 N. MAIN ST. BEL AIR, MD 21014 | | 31. Date filed (Month, Day, Year)
MAY 28 1996 | | 32. Registrar's Signature
 | | State Registrar | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 48 hours after death.

Director: After this certificate has been signed by the attending physician and completed in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

96 15670

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
ROBERT M REID | | | | 2. DATE OF DEATH
MONTH MAY DAY 24 , YEAR 1996 | | 3. TIME OF DEATH
5:35 P.M. | |
| 4. SOCIAL SECURITY NUMBER
096-22-2328 | | 5. SEX
1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
65 YRS. | | 7. DATE OF BIRTH
(Month, Day, Year)
May 25, 1930 | |
| 8. BIRTHPLACE (State or Foreign Country)
New York | | | | 9a. FACILITY NAME (If not institution, give street and number)
Lorien Nursing Home | | 9b. CITY, TOWN OR LOCATION OF DEATH
Columbia | |
| 9c. COUNTY OF DEATH
Howard | | | | 10a. STATE
Maryland | | 10b. COUNTY
Howard | |
| 10c. CITY, TOWN OR LOCATION
Columbia | | | | 10d. INSIDE CITY LIMITS?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 10e. STREET AND NUMBER
6334 Cedar Lane | |
| 10f. ZIP CODE
21044 | | | | 10g. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 11. MARITAL STATUS
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced | |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO
IF YES, GIVE WAR OR DATES
Korean | | | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | | |
| 14. RACE — American Indian, Black, White, etc.
Specify: White | | | | 15. DECEDENT'S EDUCATION
(Specify only highest grade completed)
Elementary/Secondary (0-12) 5+ College (1-4 or 5+) 5+ | | | |
| 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.)
Deputy Director of Human Resources | | | | 16b. KIND OF BUSINESS/INDUSTRY
Social Security Administration | | | |
| 17. FATHER'S NAME (First, Middle, Last)
Reginald Reid | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Martha Squires | | | |
| 19a. INFORMANT'S NAME (Type/Print)
Kenneth Reid (Son) | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
48 Stone Park Place Baltimore, Maryland 21236 | | | |
| 20a. METHOD OF DISPOSITION
1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
Metro Crematory May 29, 1996 | | | |
| 20c. LOCATION — City or Town, State
Catonsville, Maryland | | | | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
 | | | |
| 22. NAME AND ADDRESS OF FACILITY
Witzke Funeral Homes, Inc.
5555 Twin Knolls Road Columbia, Maryland | | | | 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Acute Renal Failure
DUE TO (OR AS A CONSEQUENCE OF):
b. Insulin Dependent Diabetes Mellitus
DUE TO (OR AS A CONSEQUENCE OF):
c. _____
DUE TO (OR AS A CONSEQUENCE OF):
d. _____

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | |
| 24. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
1 day
30 years | | | | PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Anemia, Diabetic Neuropathy, Multiple small strokes, Diabetic Retinopathy, Diabetic Autonomic Neuropathy | | | |
| 25. WAS AN AUTOPSY PERFORMED?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | 26. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | |
| 27. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | 28. WAS CASE REFERRED TO MEDICAL EXAMINER?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | |
| 29. PLACE OF DEATH (Check only one)
HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA
OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | 30. MANNER OF DEATH
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide
5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | | |
| 31. DATE OF INJURY (Month, Day, Year)
May 24, 1996 | | | | 32. TIME OF INJURY
M | | | |
| 33. INJURY AT WORK?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | 34. DESCRIBE HOW INJURY OCCURRED | | | |
| 35. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 36. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 37. CERTIFIER (Check only one)
1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | 38. SIGNATURE AND TITLE OF CERTIFIER
 | | | |
| 39. LICENSE NUMBER
D44 782 | | | | 40. DATE SIGNED (Month, Day, Year)
May 24, 1996 | | | |
| 41. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
JERRY ANN HUNTER 2 KNOLL NORTH DRIVE, COLUMBIA, MARYLAND 21045 | | | | | | | |
| 42. DATE FILED (Month, Day, Year)
MAY 28 1996 | | | | | | | |

DHMM-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

10

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 15671

| | | | | | | | | | | |
|--|--|---|---|--|--|---|---|---|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Julie Anne Reddinger | | | | 2. Date of Death
Month May Day 21 Year 1996 | | | | 3. Time of Death
4:30 PM | |
| | 4e. Facility Name (If not institution, give street and number)
5457 Kerger Road | | | | 4b. City, Town, or Location of Death
Ellicott City | | | | 4c. County of Death
Howard | |
| Funeral
Director | 5. Social Security Number
214-68-1608 | | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday)
40 Yrs. | | 8. Date of Birth (Month, Day, Year)
May 6, 1956 | | 9. Birthplace (State or Foreign Country)
OK | |
| | Usual Residence of Decedent | | | | | | | | | |
| To Be Completed by Funeral Director | 10a. State
MD | | 10b. County
Howard | | 10c. City, Town or Location
Ellicott City | | | | 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| | 10e. Street and Number
5457 Kerger Road | | | | 10f. Zip Code
21043 | | 10g. Citizen of What Country?
USA | | | |
| | 11. Marital Status
<input type="checkbox"/> Navar Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc.
Specify: White | | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (1-4 or 5+) None | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Homemaker | | | 16b. Kind of Business/Industry
Own Home | | |
| | 17. Father's Name (First, Middle, Last)
Kenwood J. Collard | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Carolyn Garity | | | | | |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print)
Sherman W. Reddinger (Husband) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
5457 Kerger Road, Ellicott City, MD 21043 | | | | | |
| | 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Good Shepherd Cem. | | May 25 , 1996 | | 20c. Location - City or Town, State
Ellicott City, MD | | | |
| | 21. Signature of Funeral Service Licensee
Robert Gregory Bush | | | | 22. Name and Address of Facility
Witzke Funeral Homes, Inc.
5555 Twin Knolls Rd. Columbia, MD 21045 | | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.


Immediate Cause (Final disease or condition resulting in death)
e. metastatic colon cancer
Due to (or as a consequence of):
b. Ascites
Due to (or as a consequence of):
c. Respiratory Distress
Due to (or as a consequence of):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | | | |
| | Approximate Interval Between Onset and Death
2 years
6 months
1 week | | | | | | | | | |
| State Registrar | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | |
| | | | | | | | | | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| | | | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| | 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | |
| | 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicidal <input type="checkbox"/> Homicidal
<input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how Injury occurred | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier
Paul V. Beale, MD | | 29c. License number
D 25922 (MD) | | 29d. Date signed (Month, Day, Year)
5/23/96 | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Paul V. Beale, MD, 901 Cherry Lane, Land, MD 20788 | | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
MAY 28 1996 | | | | | | | | | | |

96 15672

Certificate of Death

Reg. No.



| | | | | | | | | | | |
|--|--|---|---|--|--|--|---|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
SAMUEL A. SUGHAR | | | | 2. Date of Death
Month MAY Day 24 Year 1996 | | 3. Time of Death
0030Hr. | | | |
| | 4a. Facility Name (If not institution, give street and number)
NORTHWEST HOSPITAL CENTER | | | | 4b. City, Town, or Location of Death
RANDALLSTOWN | | 4c. County of Death
BALTIMORE | | | |
| Funeral
Director | 5. Social Security Number
214-01-1086 | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)
95 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth (Month, Day, Year)
MAR. 3, 1901 | 9. Birthplace (State or Foreign Country)
MARYLAND | | |
| | Usual Residence of Decedent | | | | | | | | | |
| To Be Completed by Funeral Director | 10a. State
MARYLAND | | 10b. County
BALTIMORE | | 10c. City, Town or Location
BALTIMORE | | | 10d. Inside City Limits
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | |
| | 10e. Street and Number
6932 MILBROOK PARK DR., APT. 2-C | | | | 10f. Zip Code
21215 | | 10g. Citizen of What Country?
USA | | | |
| | 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: WHITE | | | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 11 College (1-4or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
SHIPPING CLERK | | | 16b. Kind of Business/Industry
HUTZLER BROS. DEPT. STORE | | | | |
| | 17. Father's Name (First, Middle, Last)
PHILIP SHUGAR | | | | 18. Mother's Name (First, Middle, Maiden Surname)
SARAH UNKNOWN ZERESWITZ | | | | | |
| | 19a. Informant's Name/Relationship (Type, Print)
MRS. IDA N. SUGHAR (WIFE) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
6932 MILBROOK PARK DRIVE, APT. 2-C BALTIMORE, MD 21215 | | | | | |
| | 20a. Method of Disposition
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
BETH ISAAC ADATH ISRAEL 5-26-1996 BALTIMORE, MD | | Date | | 20c. Location - City or Town, State | | | |
| | 21. Signature of Funeral Service Licensee
 | | | | 22. Name and Address of Facility
SOL LEVINSON & BROS., INC.
8900 REISTERSTOWN ROAD PIKESVILLE, MD 21208 | | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. CONGESTIVE CARDIOMYOPATHY
Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last | | | | | | | | Approximate Interval Between Onset and Death | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
RENAL FAILURE, ANEMIA | | | | | | | | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown | |
| 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | |
| 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | | |
| 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | | |
| 29a. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier
 | | 29c. License number
D 37333 | | 29d. Date signed (Month, Day, Year)
MAY 24, 1996 | | | | |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)
C. RAVI MD, RANDALLSTOWN MD 21133 | | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
MAY 28 1996 | | 32. Registrar's Signature
 | | | | | | | | |

Baltimore, Maryland 21215-0020
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 15673

Certificate of Death

Reg. No.

| | | | | | | | | | |
|---|---|---|--|--|---|---|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
JOSEPHINE FRANCES SMITH | | | | 2. Date of Death
Month MAY Day 24 Year 1996 | | 3. Time of Death
12=40PM | | |
| | 4a. Facility Name (If not institution, give street and number)
ER FALLSTON GENERAL HOSPITAL | | | | 4b. City, Town, or Location of Death
FALLSTON | | 4c. County of Death
HARFORD | | |
| Funeral
Director | 5. Social Security Number
216-03-6000 | | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)
79 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth (Month, Day, Year)
October 21, 1916 | | |
| | 9. Birthplace (State or Foreign Country)
Maryland | | | | | | | | |
| Usual Residence of Decedent | | | | | | | | | |
| 10a. State
Maryland | | 10b. County
Baltimore | | 10c. City, Town or Location
Rosedale | | | 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 10e. Street and Number
5419 Cynthia Terrace | | | | 10f. Zip Code
21206 | | 10g. Citizen of What Country?
United States | | | |
| 11. Marital Status
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: White | | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 7 College (1-4or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Homemaker | | 16b. Kind of Business/Industry
Own Home | | | |
| 17. Father's Name (First, Middle, Last)
Joseph Kwiatkowski | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Frances Slawinski | | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
Mrs. Constance M. Kozak/Daughter | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
400 Birchwood Manor Lane Belair, Md. 21014 | | | | | |
| 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Oak Lawn Cemetery | | Date
5/28/96 | | 20c. Location - City or Town, State
Baltimore, Maryland | | | |
| 21. Signature of Funeral Service Licensee Mark T. Zavoyna | | | | 22. Name and Address of Facility
Leonard J. Ruck, Inc.
5305 Harford Road Baltimore, Md. 21214 | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
e. ACUTE CORONARY ARTERY DISEASE
Due to (or as a consequence of):
b. ASVD
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | | | |
| 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | | | | | | | | |
| 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
HYPERTENSION, HYPERLIPIDEMIA
SJP CASSQ | | | | | | | | | |
| 25. Was case referred to medical examiner?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation
<input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined
<input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day, Year)
NA | | 28b. Time of Injury
NA M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred
NA | |
| | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
NA | | 28f. Location (Street and Number or Rural Route Number, City or Town, State)
NA | | | | | |
| 29a. Certifier (Check only one)
<input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier
[Signature] DME | | | | | | | |
| | | 29c. License number
OCME | | 29d. Date signed (Month, Day, Year)
MAY 24 1996 | | | | | |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)
A.S. PRASHU 1810 BELAIR RD FALLSTON MD 21047 - 410-879-6564 | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
MAY 28 1996 | | 32. Registrar's Signature
[Signature] | | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 15674

Certificate of Death

Reg. No.

| | | | | | | | | |
|--|--|---|--|--|---|---|---|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
MINNIE SCHERR | | | | 2. Date of Death
Month Day Year
MAY 24, 1996 | | 3. Time of Death
4am | |
| | 4a. Facility Name (If not institution, give street and number)
CHERRYWOOD MANOR NURSING HOME | | | | 4b. City, Town, or Location of Death
REISTERSTOWN | | 4c. County of Death
BALTIMORE | |
| Funeral
Director | 5. Social Security Number
215-03-5164 | | 6. Sex
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday)
84 Yrs. | | 8. Date of Birth (Month, Day, Year)
DEC. 23, 1911 | |
| | 9. Birthplace (State or Foreign Country)
MARYLAND | | 10a. State
MARYLAND | | 10b. County
BALTIMORE | | 10c. City, Town or Location
OWINGS MILLS | |
| 10d. Inside City Limits
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 10e. Street and Number
11 INDIAN PONY COURT | | 10f. Zip Code
21117 | | 10g. Citizen of What Country?
USA | | |
| 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: WHITE | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (1-4 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
SALESLADY | | 16b. Kind of Business/Industry
HUTZLERS DEPT. STORE | | | | |
| 17. Father's Name (First, Middle, Last)
SIMON MINKOVE | | 18. Mother's Name (First, Middle, Maiden Surname)
DENA UNKNOWN | | | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
MRS. SHARON SILVERMAN (DAUGHTER) | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
11 INDIAN PONY CT. OWINGS MILLS, MD 21117 | | | | | | |
| 20a. Method of Disposition
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
ADATH YESHURUN | | 20c. Location - City or Town, State
5-26-1996-BALTIMORE, MD | | | | |
| 21. Signature of Funeral Service Licensee
<i>Scott M. Cuthbert</i> | | 22. Name and Address of Facility
SOL LEVINSON & BROS., INC.
8900 REISTERSTOWN ROAD PIKESVILLE, MD 21208 | | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

a. <i>Probable Myocardial Infarct</i>
Due to (or as a consequence of):

b. <i>Coronary Artery Disease</i>
Due to (or as a consequence of):

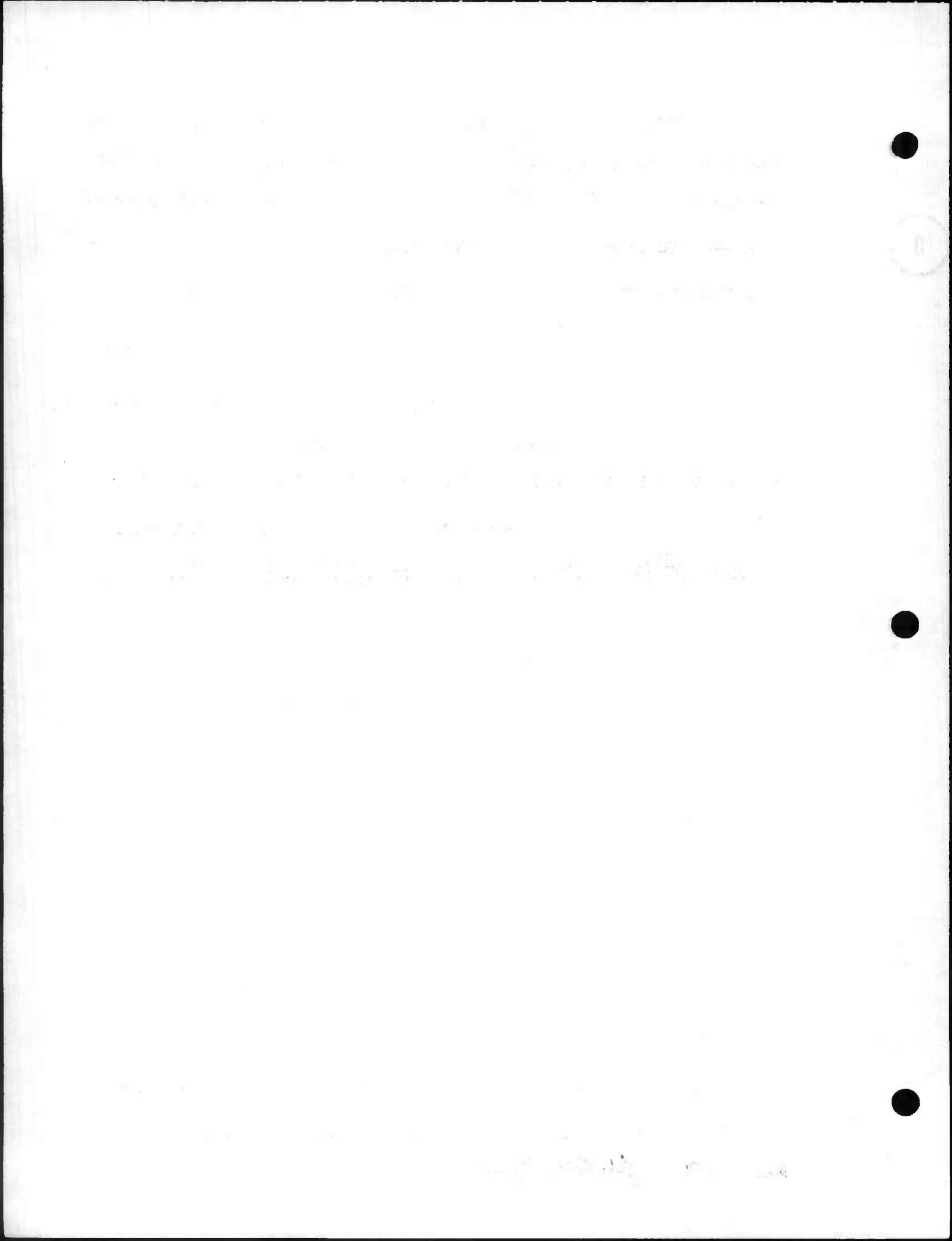
c.
Due to (or as a consequence of):

d.
Due to (or as a consequence of): | | Approximate Interval Between Onset and Death | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
<i>Premi recent Myocardial Infarct</i>
<i>Atherosclerotic Disease</i> | | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | |
| 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide
5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year)
5/24/96 | | |
| 28b. Time of Injury
M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | | 28e. Location (Street and Number or Rural Route Number, City or Town, State) | | |
| 29a. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier
<i>Steph S. [Signature]</i> | | 29c. License number
028304 | | 29d. Date signed (Month, Day, Year)
5/24/96 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
750 Main St. Reisterstown MD 21136 | | 31. Date filed (Month, Day, Year)
MAY 28 1996 | | 32. Registrar's Signature
<i>Julia Davidson-Mendell</i> | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

State Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 15675

Certificate of Death

Reg. No.

| | | | | | | | | |
|--|---|--|--|--|---|--------------------------------|---|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
BERTNA STRONG | | | | 2. Date of Death
Month Day Year
MAY 26 1996 | | 3. Time of Death
19.07. | |
| | 4a. Facility Name (If not institution, give street and number)
GOOD SAMARITAN HOSPITAL | | | | 4b. City, Town, or Location of Death
BALTIMORE CITY. | | 4c. County of Death
N/A | |
| Funeral
Director | 5. Social Security Number
247-18-5254 | | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)
78 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth
(Month, Day, Year)
Jan. 14, 1918 | 9. Birthplace (State or Foreign County)
South Carolina |
| | Usual Residence of Decedent | | | | 10c. City, Town or Location
Baltimore | | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | |
| To Be Completed by Funeral Director | 10a. State
Maryland | | 10b. County
N/A | | 10e. Street and Number
1343 Pentwood Rd. | | 10f. Zip Code
21239 | |
| | 10g. Citizen of What Country?
USA | | 11. Marital Status
<input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | |
| | 15. Decedent's Education
(Specify only highest grade completed)
Elementary/Secondary (0-12) 6 College (1-4or 5+) 0 | | 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)
Domestic Worker | | 16b. Kind of Business/Industry
Outside Home | | | |
| | 17. Father's Name (First, Middle, Last)
Will Worthy | | 18. Mother's Name (First, Middle, Maiden Surname)
Janie Jackson | | 19. Informant's Name/Relationship (Type, Print)
Mrs. Barbara Crosby | | | |
| Physician
/Medical
Examiner | 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Woodlawn | | 20c. Location - City or Town, State
Balto. Co. Md. | | 21. Signature of Funeral Service Licensee
Joseph L. Russ | |
| | 22. Name and Address of Facility
Joseph L. Russ Funeral Home | | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
STREPTOCOCCAL BACTEREMIA | | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | |
| | 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify) | | 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | |
| | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | |
| Medical Certification: To Be Completed by Physician/Medical Examiner | 28a. Place of injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | 29a. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | |
| | 29b. Signature and title of certifier
MD | | 29c. License number
PO 9307 | | 29d. Date signed (Month, Day, Year)
MAY 26, 1996 | | | |
| | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
UMA RANI, GOOD SAMARITAN HOSPITAL, BALTIMORE CITY | | | | | | | |
| | 31. Date filed (Month, Day, Year)
MAY 28 1996 | | 32. Registrar's Signature
John L. ... | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

96 15676

Reg. No.

| | | | | | | | | |
|--|--|--|--|--|--|--|---|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
William Smallwood | | | | 2. Date of Death
Month Day Year
May 21 1996 | | 3. Time of Death
11:20 p.m. | |
| | 4a. Facility Name (If not institution, give street and number)
North Charles Health Care | | | | 4b. City, Town, or Location of Death
Baltimore | | 4c. County of Death
N/A | |
| Funeral
Director | 5. Social Security Number
218-09-7174 | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday)
81 Yrs. | | 8. Date of Birth (Month, Day, Year)
Aug. 8, 1914 | |
| | 9. Birthplace (State or Foreign Country)
N. CAROLINA | | 10a. State
Maryland | | 10b. County
N/A | | 10c. City, Town or Location
Baltimore | |
| To Be Completed by Funeral Director | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 10e. Street and Number
909 Walnut Avenue | | 10f. Zip Code
21229 | | 10g. Citizen of What Country?
U.S.A. | |
| | 11. Marital Status
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: BLACK | |
| To Be Completed by Physician/Medical Examiner | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) <input checked="" type="checkbox"/> 5
College (1-4or 5+) <input type="checkbox"/> | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
LABORER | | 16b. Kind of Business/Industry
Longshoreman Ass. | | 17. Father's Name (First, Middle, Last)
Thomas Smallwood | |
| | 18. Mother's Name (First, Middle, Maiden Surname)
Elizabeth Bazemore | | 19a. Informant's Name/Relationship (Type, Print)
Alice Marie Smallwood | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
909 Walnut Ave. Baltimore Md 21229 | | 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | |
| To Be Completed by Physician/Medical Examiner | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Garden of Eternal Rest, Finksburg, Md | | 20c. Location (City or Town, State)
Finksburg, Md | | 21. Signature of Funeral Service Licensee
Shirley Adams Jones | | 22. Name and Address of Facility
MARSHALL W. JONES, JR. FUNERAL HOME PA
4101 Edmondson Ave. Balto. Md. 21229 | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

a. Prostate Cancer
Due to (or as a consequence of):
b. Cerebrovascular accident
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d. | | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one)
Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | |
| | 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
5 <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| To Be Completed by Physician/Medical Examiner | 28d. Describe how injury occurred | | 28e. Location (Street and Number or Rural Route Number, City or Town, State) | | 29a. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier
Robert K. Roby | |
| | 29c. License number
037928 | | 29d. Date signed (Month, Day, Year)
5/23/96 | | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Robert K. Roby, M.D. 2735 N. Charles Street Baltimore, Md. 21218 | | 31. Data filed (Month, Day, Year)
MAY 28 1996 | |
| 32. Registrar's Signature
Raymond R. Riddle | | | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 15677

| | | | | | | | | | | | |
|--|--|--|---|---|--|---------------------------------|---|--|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Mary Louise Steidtmann | | | | 2. Date of Death
Month May Day 7 Year 1996 | | 3. Time of Death
2:38 p.m. | | | | |
| | 4a. Facility Name (If not institution, give street and number)
500 Bramblewood Drive-#102 | | | | 4b. City, Town, or Location of Death
Abingdon | | 4c. County of Death
Harford | | | | |
| Funeral
Director | 5. Social Security Number
213-26-5100 | | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)
66 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth (Month, Day, Year)
Feb. 17, 1930 | 9. Birthplace (State or Foreign Country)
Maryland | | | |
| | Usual Residence of Decedent | | | | | | | | | | |
| To Be Completed by Funeral Director | 10a. State
Maryland | | 10b. County
Harford | | 10c. City, Town or Location
Abingdon | | | 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | |
| | 10e. Street and Number
500 Bramblewood Drive-#102 | | | | 10f. Zip Code
21009 | | 10g. Citizen of What Country?
U.S.A. | | | | |
| | 11. Marital Status
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc.
Specify: White | | | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12th College (1-4 or 5+) 0 | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Receptionist | | | 16b. Kind of Business/Industry
Service | | | |
| | 17. Father's Name (First, Middle, Last)
William Guy Boylan | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Anna Elizabeth O'Hara | | | | | | |
| | 19a. Informant's Name/Relationship (Type, Print)
Tam Emerick/Son | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
3735 Gibbons Avenue-Baltimore, Maryland 21206 | | | | | | |
| | 20a. Method of Disposition
<input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input checked="" type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) | | Data | | 20c. Location - City or Town, State | | | |
| | 21. Signature of Funeral Service Licensee

Ronald S. Wade, Dir. | | | | 22. Name and Address of Facility
State Anatomy Board-655 W. Baltimore Street
Baltimore, Maryland 21201-1559 | | | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. chronic obstructive lung disease
Due to (or as a consequence of):
b. Broncheal Asthma
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | | Approximate Interval Between Onset and Death
6 yrs. | | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Cardiomyopathy - Congestive heart failure | | | | | | | | 23b. Did tobacco use contribute to the cause of death?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | |
| | | | | | | | | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accidental <input type="checkbox"/> Suicidal <input type="checkbox"/> Homicidal <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input type="checkbox"/> No | | 28d. Describe how injury occurred | |
| | | | | 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | 29b. Signature and title of certifier

B.D. PAREKH MD | | | | 29c. License number
218424 | | 29d. Date signed (Month, Day, Year)
May - 16 - 96 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
B.D. PAREKH MD 1908 HARFORD ROAD FAULSTON MD 21047 | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
MAY 28 1996 | | | | 32. Registrar's Signature
 | | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 15678

| | | | | | | | | | |
|---|--|--|--|---|---|--|---|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
CARRIE M. SCOTT | | | | 2. Date of Death
Month Day Year
MAY 24, 1996 | | 3. Time of Death
1:30 PM | | |
| | 4e. Facility Name (If not institution, give street and number)
ST. JOSEPH MEDICAL CENTER | | | | 4b. City, Town, or Location of Death
TOWSON | | 4c. County of Death
BALTIMORE | | |
| Funeral
Director | 5. Social Security Number
258-22-1274 | | 6. Sex
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday)
66 Yrs. | | 8. Date of Birth (Month, Day, Year)
AUG. 22, 1929 | | |
| | 9. Birthplace (State or Foreign Country)
GEORGIA | | 10a. State
MARYLAND | | 10b. County
N/A | | 10c. City, Town or Location
BALTIMORE | | |
| Usual Residence of Decedent | | 10d. Inside City Limits
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 10e. Street and Number
2418 GUILFORD AVE. | | 10f. Zip Code
21218 | | 10g. Citizen of What Country?
U.S.A. | |
| 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever In U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: BLACK | | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) College (1-4 or 5+)
MA | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
TEACHER | | 16b. Kind of Business/Industry
BALTIMORE CITY | | 17. Father's Name (First, Middle, Last)
WILLIAM HENRY SMITH | | 18. Mother's Name (First, Middle, Maiden Surname)
FANNIE | |
| 19e. Informant's Name/Relationship (Type, Print)
SHARON QUEEN-DAUGHTER | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
5606 DENWOOD AVE. BALTO, MD. 21206 | | 20e. Method of Disposition
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
ARBUTUS MEM. PK. MAY 30, 1996 BALTO, MD. | | 20c. Location - City or Town, State | |
| 21. Signature of Funeral Service Licensee
<i>Calvin B. Scruggs, Jr.</i> | | 22. Name and Address of Facility
CALVIN B. SCRUGGS FUNERAL HOME
1412 E. PRESTON ST. BALTO, MD. 21213 | | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
ANOXIC ENCEPHALOPATHY | | Approximate Interval Between Onset and Death
2 DAYS | | | |
| Immediate Cause (Final disease or condition resulting in death)
a. Due to (or as a consequence of): | | b. Due to (or as a consequence of): | | c. Due to (or as a consequence of): | | d. Due to (or as a consequence of): | | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last | | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | |
| 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA | | 26. Place of Death (Check only one)
Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide
5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of injury (Month, Day, Year) | |
| 28b. Time of Injury
M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | |
| 29e. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier
<i>Francis Khoo</i> | | 29c. License number
D 30263 | | 29d. Date signed (Month, Day, Year)
05-24-96 | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
FRANCIS KHOO, M.D., 7620 YORK ROAD, TOWSON, MARYLAND 21204 | | 31. Date filed (Month, Day, Year)
MAY 28 1996 | | 32. Registrar's Signature
<i>Francis Khoo</i> | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 15679

Certificate of Death

Reg. No.

| | | | | | | | | | | | | | | | | | |
|---|--|---|---|--|--|--|---|--|---|--|---|-----------------------------------|----------------|---|----------------|----------|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
ARLETTA SCHISLER | | | | 2. Date of Death
Month Day Year
MAY 25 1996 | | 3. Time of Death
8:12 AM | | | | | | | | | | |
| | 4a. Facility Name (If not institution, give street and number)
HARBOR HOSPITAL CENTER | | | | 4b. City, Town, or Location of Death
BALTIMORE | | 4c. County of Death
BALTIMORE | | | | | | | | | | |
| Funeral
Director | 5. Social Security Number
212-26-1898 | | 6. Sex
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday)
66 Yrs. | | 8. Date of Birth (Month, Day, Year)
FEB 26, 1930 | | | | | | | | | | |
| | 9. Birthplace (State or Foreign Country)
Maryland | | 10a. State
Maryland | | 10b. County
Anne Arundel | | 10c. City, Town or Location
Glen Burnie | | | | | | | | | | |
| To Be Completed by Funeral Director | 10d. Inside City Limits
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 10e. Street and Number
301 Oak Manor Dr. Apt. T-4 | | 10f. Zip Code
21061 | | 10g. Citizen of What Country?
USA | | | | | | | | | | |
| | 11. Marital Status
1 <input type="checkbox"/> Navar Married 2 <input type="checkbox"/> Married
3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: White | | | | | | | | | | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (1-4 or 5+) College | | 16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Homemaker | | 16b. Kind of Business/Industry
Home | | | | | | | | | | | | |
| | 17. Father's Name (First, Middle, Last)
Charles Llewellyn Cross | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Mary Anna Conrad | | | | | | | | | | | | |
| | 19a. Informant's Name/Relationship (Type, Print)
Donald Kenwood Schisler/Stepson | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1205 Lotus Ave. Glen Burnie, MD 21061 | | | | | | | | | | | | |
| | 20a. Method of Disposition
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Woodlawn Cemetery 5/29/96 | | 20c. Location - City or Town, State
Woodlawn, MD | | | | | | | | | | | | |
| | 21. Signature of Funeral Service Licensee
George E. MacNabb | | | | 22. Name and Address of Facility
MacNabb Funeral Home, P.A.
301 Frederick Rd. Baltimore, MD 21228 | | | | | | | | | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | | | | | | | | | | |
| | <table border="1"> <tr> <td rowspan="4">Immediate Cause (Final disease or condition resulting in death)</td> <td>a. ENTEROCOCCAL SEPTICEMIA</td> <td>Approximate Interval Between Onset and Death
4 DAYS</td> </tr> <tr> <td>b. ADENOCARCINOMA OF COLON</td> <td>20 DAYS</td> </tr> <tr> <td>c. LARYNGEAL CANCER</td> <td>5 YEARS</td> </tr> <tr> <td>d. _____</td> <td></td> </tr> </table> | | | | | | | | Immediate Cause (Final disease or condition resulting in death) | a. ENTEROCOCCAL SEPTICEMIA | Approximate Interval Between Onset and Death
4 DAYS | b. ADENOCARCINOMA OF COLON | 20 DAYS | c. LARYNGEAL CANCER | 5 YEARS | d. _____ | |
| | Immediate Cause (Final disease or condition resulting in death) | a. ENTEROCOCCAL SEPTICEMIA | Approximate Interval Between Onset and Death
4 DAYS | | | | | | | | | | | | | | |
| b. ADENOCARCINOMA OF COLON | | 20 DAYS | | | | | | | | | | | | | | | |
| c. LARYNGEAL CANCER | | 5 YEARS | | | | | | | | | | | | | | | |
| d. _____ | | | | | | | | | | | | | | | | | |
| <table border="1"> <tr> <td colspan="2">Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
ENTEROCOCCAL UROSEPSIS.</td> <td colspan="2">23b. Did tobacco use contribute to the cause of death?
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown</td> </tr> <tr> <td colspan="2"></td> <td colspan="2">24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</td> </tr> </table> | | | | | | | | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
ENTEROCOCCAL UROSEPSIS. | | 23b. Did tobacco use contribute to the cause of death?
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | | 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
ENTEROCOCCAL UROSEPSIS. | | 23b. Did tobacco use contribute to the cause of death?
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | | | | | | | | | | | | | |
| | | 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | | | | | | | | | | | |
| 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | | | | | | | | | |
| 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of injury (Month, Day Year) | | 28b. Time of injury
M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | | | | | | | |
| | | 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | | | | | | |
| 29e. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | | | | | | | | |
| 29b. Signature and title of certifier
J. Jassi HOUSE-STAFF. | | | | 29c. License number
AS2441614-64 | | 29d. Date signed (Month, Day, Year)
MAY 25th 1996 | | | | | | | | | | | |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)
SUKHPAL JASSI, HARBOR HOSPITAL CTR. 3001, S. HANOVER ST BALTIMORE, MD | | | | | | | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
MAY 28 1996 | | 32. Registrar's Signature
[Signature] | | | | | | | | | | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Reg. No.

| | | | | | | | | | | | |
|--|--|---|--|---|---|---|---|--|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last) WILSON JENNINGS SMALLWOOD SR. | | | | 2. Date of Death
Month May Day 23 Year 1996 | | | | 3. Time of Death
7:10pm | | |
| | 4a. Facility Name (If not institution, give street and number)
North Arundel Hospital 301 Hospital Drive | | | | 4b. City, Town, or Location of Death
Glen Burnie | | | | 4c. County of Death
Anne Arundel | | |
| Funeral
Director | 5. Social Security Number
232-10-3855 | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)
80 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth (Month, Day, Year)
9/20/15 | | 9. Birthplace (State or Foreign Country)
WEST VIRGINIA | | |
| | Usual Residence of Decedent | | | | | | | | | | |
| 10e. State
MARYLAND | | 10b. County
ANNE ARUNDEL | | 10c. City, Town or Location
GLEN BURNIE | | | | 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | |
| 10e. Street and Number
106 KENT ROAD | | | | 10f. Zip Code
21060 | | | | 10g. Citizen of What Country?
U.S.A. | | | |
| 11. Marital Status
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | | 14. Race - American Indian, Black, White, etc.
Specify: WHITE | | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 11 College (1-4 or 5+) NONE | | | | 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
ENGINEER | | | | 16b. Kind of Business/Industry
RAILROAD | | | |
| 17. Father's Name (First, Middle, Last)
HOWARD | | | | 18. Mother's Name (First, Middle, Maiden Surname)
VIRGINIA LEE ATKINS | | | | | | | |
| 19e. Informant's Name/Relationship (Type, Print)
WILSON J. SMALLWOOD JR. | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
747 HYDE PARK DR., GLEN BURNIE, MD 21061 | | | | | | | |
| 20e. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
GLEN HAVEN MEMORIAL PK. | | Date
5/28/96 | | 20c. Location - City or Town, State
GLEN BURNIE, MARYLAND | | | | | |
| 21. Signature of Funeral Service Licensee
 | | | | 22. Name and Address of Facility
SINGLETON FUNERAL HOME
1 SECOND AVE. S.W., GLEN BURNIE, MD 21061 | | | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
e. Sigmoid Colon Cancer
Due to (or as a consequence of):
b. Chronic Obstructive Pulmonary Disease
Due to (or as a consequence of):
c. Sepsis
Due to (or as a consequence of):
d.

Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | | | | Approximate Interval Between Onset and Death
1 month
1 year
3 days | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Atrial Fibrillation, Hypertension | | | | | | | | | | | |
| 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | | | | | | | | | | |
| 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | | | |
| 28e. Piece of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | | | | |
| 29b. Signature and title of certifier
Dr. H. Schuchter MD | | | | 29c. License number
DZ8221 | | | | 29d. Date signed (Month, Day, Year)
MAY 23, 1996 | | | |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)
Dr. H. Schuchter MD 301 Hospital Drive Glen Burnie Maryland | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
MAY 28 1996 | | | | 32. Registrar's Signature
John A. Schuchter
21061 | | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 15681

Certificate of Death

Reg. No.

| | | | | | | | | |
|--|---|---|--|---|---|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
EMMA T. SEAL | | | | 2. Date of Death
Month MAY Day 24 Year 1996 | | 3. Time of Death
10:50PM | |
| | 4a. Facility Name (If not institution, give street and number)
HOWARD COUNTY GENERAL HOSPITAL | | | | 4b. City, Town, or Location of Death
COLUMBIA | | 4c. County of Death
HOWARD | |
| Funeral
Director | 5. Social Security Number
220-18-4528 | | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)
74 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth (Month, Day, Year)
Mar. 23, 1922 | 9. Birthplace (State or Foreign Country)
TN |
| | Usual Residence of Decedent | | | | | | | |
| 10a. State
MD | | 10b. County
Howard | | 10c. City, Town or Location
Columbia | | | 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 10e. Street and Number
9076 Wild Apple | | | | 10f. Zip Code
21045 | | 10g. Citizen of What Country?
USA | | |
| 11. Marital Status
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- if Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc.
Specify: White | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 8 College (1-4or 5+) None | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Homemaker | | | 16b. Kind of Business/Industry
Own Home | |
| 17. Father's Name (First, Middle, Last)
Wint Ferguson | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Melissa Sutton | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
Donna Evans (Daughter) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
9076 Wild Apple, Columbia, MD 21045 | | | | |
| 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Crestlawn Cemetery | | 20c. Location - City or Town, State
Marriottsville, MD | | |
| 21. Signature of Funeral Service Licensee
 | | | | 22. Name and Address of Facility
Witzke Funeral Homes, Inc.
5555 Twin Knolls Rd. Columbia, MD 21045 | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. Acute embolic CVA
Due to (or as a consequence of):
b. HPN
Due to (or as a consequence of):
c. chronic atrial fibrillation
Due to (or as a consequence of):
d. Mitral stenosis | | | | | | | | Approximate interval Between Onset and Death
3 days
10 yrs
several yrs
several yrs |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown | | |
| | | | | | | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one)
Hospital: <input checked="" type="checkbox"/> inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of injury (Month, Day Year) | | 28b. Time of injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred |
| | | | | 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier
 | | 29c. License number
D 34974 | | 29d. Date signed (Month, Day, Year)
May 25th 1996 | | |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)
CHARU MEHTA, MD 5865 Robert Oliver place #121 Columbia, MD 21045 | | | | | | | | |
| 31. Date filed (Month, Day, Year)
MAY 28 1996 | | | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filed in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 15682

Certificate of Death

Reg. No.

| | | | | | | | | | | | |
|---|--|---|---|---|---|--|---|---|--|---|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Agnes STANLEY | | | | 2. Date of Death
Month Day Year
May 23, 1996 | | | | 3. Time of Death
4:57 PM | | |
| | 4a. Facility Name (If not institution, give street and number)
Franklin Square Hospital | | | | 4b. City, Town, or Location of Death
N/A | | | | 4c. County of Death
Baltimore | | |
| Funeral
Director | 5. Social Security Number
220-18-3593 | | 6. Sex
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday)
68 Yrs. | | 8. Date of Birth (Month, Day, Year)
Sept 9, 1927 | | 9. Birthplace (State or Foreign Country)
Maryland | | |
| | Usual Residence of Decedent | | | | | | | | | | |
| To Be Completed by Funeral Director | 10a. State
Md | | 10b. County
Baltimore | | 10c. City, Town or Location
N/A | | | | 10d. Inside City Limits
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | |
| | 10e. Street and Number
527 Southern Ave | | | | 10f. Zip Code
21224 | | 10g. Citizen of What Country?
USA | | | | |
| | 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc.
Specify: White | | | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 9 Collegia (1-4 or 5+) | | | | 18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Waitress | | | 18b. Kind of Business/Industry
Restaurant | | | |
| | 17. Father's Name (First, Middle, Last)
Ignatious Szymanski | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Angelean Gostomski | | | | | | |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print)
Kenneth Stanley / husband | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
527 Southern Ave Baltimore, Md 21224 | | | | | | |
| | 20a. Method of Disposition
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Sacred Heart of Mary | | Data
5/27 | | 20c. Location - City or Town, State
Baltimore, Md | | | | |
| | 21. Signature of Funeral Service Licensee
<i>Anthony Colt Connolly</i> | | | | 22. Name and Address of Facility
Connolly Funeral Home of Dundalk
7110 Sollers Point Rd 21222 | | | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Acute left ventricular failure
acute myocardial infarct. | | | | | | | | | | |
| | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown | | | | | | | | | | |
| 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | |
| 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | | | | 26. Place of Death (Check only one)
Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | |
| 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide
5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | | | |
| 29a. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | 29b. Signature and title of certifier
<i>[Signature]</i> | | 29c. License number
D10613 | | 29d. Date signed (Month, Day, Year)
5-24-96 | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Rafael Perez-Mera, M.D. 404 Eastern Blvd Baltimore, Md 21221 | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
MAY 28 1996 | | 32. Registrar's Signature
<i>[Signature]</i> | | | | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

96 15683

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
William Edward Tillman | | | | 2. DATE OF DEATH
MONTH May DAY 12 YEAR 1996 | | 3. TIME OF DEATH
345A M | |
| 4. SOCIAL SECURITY NUMBER
NONE | | 5. SEX
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
YRS. MONTHS DAYS | | 7. DATE OF BIRTH
(Month, Day, Year)
May 12, 1996 | |
| 8. BIRTHPLACE (State or Foreign Country)
Maryland | | | | 9. FACILITY NAME (If not institution, give street and number)
Southern Maryland Hospital | | | |
| 10. CITY, TOWN OR LOCATION OF DEATH
Clinton | | | | 11. COUNTY OF DEATH
Prince Georges | | | |
| 12a. STATE
Maryland | | 12b. COUNTY
Prince Georges | | 12c. CITY, TOWN OR LOCATION
Clinton | | 12d. INSIDE CITY LIMITS?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 13a. STREET AND NUMBER
4807 Megan Drive | | | | 13b. ZIP CODE
20735 | | 13c. CITIZEN OF WHAT COUNTRY?
USA | |
| 14. MARITAL STATUS
<input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 15. WAS DECEDENT EVER IN U.S. ARMED FORCES?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 16. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 17. RACE — American Indian, Black, White, etc.
Specify: Black | |
| 18. DECEDENT'S EDUCATION
(Specify only highest grade completed)
NONE | | 19. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.)
NONE | | 20. KIND OF BUSINESS/INDUSTRY
NONE | | | |
| 21. FATHER'S NAME (First, Middle, Last)
William Ward | | | | 22. MOTHER'S NAME (First, Middle, Maiden Surname)
Wanda Denise Tillman | | | |
| 23. INFORMANT'S NAME (Type/Print)
Nanda Denise Tillman | | | | 24. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
4807 Megan Drive Clinton, Md. 20735 | | | |
| 25a. METHOD OF DISPOSITION
<input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input checked="" type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 25b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
DATE | | 25c. LOCATION — City or Town, State | | | |
| 26. SIGNATURE OF FUNERAL SERVICE LICENSEE
Ronald S. Wade, Dir. | | | | 27. NAME AND ADDRESS OF FACILITY
State Anatomy Board-655 W. Baltimore Street
Baltimore, Maryland 21201-1559 | | | |
| 28. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
IMMEDIATE CAUSE (Final disease or condition resulting in death) → Immaturity
DUE TO (OR AS A CONSEQUENCE OF):
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. DUE TO (OR AS A CONSEQUENCE OF):
c. DUE TO (OR AS A CONSEQUENCE OF):
d. | | | | | | Approximate Interval Between Onset and Death | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 29a. WAS AN AUTOPSY PERFORMED?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | 29b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
<input type="checkbox"/> YES <input type="checkbox"/> NO | |
| 30. WAS CASE REFERRED TO MEDICAL EXAMINER?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 31. PLACE OF DEATH (Check only one)
HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA
OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 32. MANNER OF DEATH
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation
<input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | 33a. DATE OF INJURY (Month, Day, Year)
NONE | | 33b. TIME OF INJURY
M | | 33c. INJURY AT WORK?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 34. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
NONE | | 35. DESCRIBE HOW INJURY OCCURRED
NONE | | | | | |
| 36. CERTIFIER (Check only one)
<input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 37. SIGNATURE AND TITLE OF CERTIFIER
Ernesto Gallardo, M.D. | | 38. LICENSE NUMBER
D42190 | | 39. DATE SIGNED (Month, Day, Year)
5/12/96 | |
| 40. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
Ernesto Gallardo, M.D. 7503 Surratts Rd. Clinton, Md. 20735 | | | | | | | |
| 41. DATE FILED (Month, Day, Year)
MAY 28 1996 | | 42. REGISTRAR'S SIGNATURE
[Signature] | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 15684

Certificate of Death

Reg. No.

| | | | | | | | | | | | |
|--|---|---|---|---|--|---|--|--|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Cecilia M. Thorn | | | | | 2. Date of Death
Month Day Year
May 23, 1996 | | 3. Time of Death
9:00 PM | | | |
| | 4e. Facility Name (If not institution, give street and number)
7026 Fieldcrest Rd. | | | | | 4b. City, Town, or Location of Death
Baltimore | | 4c. County of Death
N/A | | | |
| Funeral
Director | 5. Social Security Number
216-44-1855 | | 6. Sex
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday)
50 Yrs. | | 8. Date of Birth (Month, Day, Year)
July 27, 1945 | | 9. Birthplace (State or Foreign Country)
New York | | |
| | Usual Residence of Decedent | | | | | 10c. City, Town or Location
Baltimore | | 10d. Inside City Limits
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | |
| 10e. State
Maryland | | 10b. County
N/A | | 10f. Zip Code
21215 | | | | | 10g. Citizen of What Country?
USA | | |
| 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | | 14. Race - American Indian, Black, White, etc.
Specify: White | | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) College (1-4 or 5+)
12 years | | | | 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Newspaper Distributor | | | | 16b. Kind of Business/Industry
Baltimore Sun | | | |
| 17. Father's Name (First, Middle, Last)
Harry Walsh | | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Cecilia Stegaman | | | | | | |
| 19e. Informant's Name/Relationship (Type, Print)
Joseph J. Thorn III (Husband) | | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
7026 Fieldcrest Rd. Baltimore, MD 21215 | | | | | | |
| 20e. Method of Disposition
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Woodlawn Cemetery | | | 20c. Location - City or Town, State
5-28-96 Woodlawn, Maryland | | | | | |
| 21. Signature of Funeral Service Licensee
 | | | | | 22. Name and Address of Facility
Loring Byers Funeral Directors, Inc.
8728 Liberty Rd. Randallstown, MD 21133 | | | | | | |
| 23a. Pertinent disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
e. COLON CANCER
Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last | | | | | | | | | | Approximate Interval Between Onset and Death
11 MONTHS | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | | | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | |
| | | | | | | | | | | 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | |
| | | | | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | 26. Place of Death (Check only one)
Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | | |
| 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide
5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | | |
| | | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | | |
| 29b. Signature and title of certifier
 | | | | | 29c. License number
D305606 | | 29d. Date signed (Month, Day, Year)
5/24/96 | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
SAMUEL HESTER, MD, 21 SPOFFORD DR, SUTHERLAND, MD 21157 | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
MAY 28 1996 | | | | | | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 15685

Certificate of Death

Reg. No.

| | | | | | | | | |
|---|--|---------------------------------|---|---|--|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Linda TOMBLIN | | | | 2. Date of Death
Month May Day 25 Year 1996 | | 3. Time of Death
9:39 a.m. | |
| | 4a. Facility Name (If not institution, give street and number)
Franklin Square Hospital Center | | | | 4b. City, Town, or Location of Death
Rossville | | 4c. County of Death
Baltimore | |
| Funeral
Director | 5. Social Security Number
236 66 6110 | | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)
54 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth (Month, Day, Year)
Oct. 22, 1941 | 9. Birthplace (State or Foreign Country)
West Virginia |
| | Usual Residence of Decedent | | | | | | | |
| 10a. State
Maryland | | 10b. County
Baltimore | | 10c. City, Town or Location
Essex | | | 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 10e. Street and Number
341 Homberg Avenue | | | | 10f. Zip Code
21221 | | 10g. Citizen of What Country?
U.S.A. | | |
| 11. Marital Status
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: White | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 8 College (1-4or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Housewife | | 16b. Kind of Business/Industry
Own Home | | |
| 17. Father's Name (First, Middle, Last)
Clifford Farris | | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Donna Ramsey | | | |
| 19a. Informant's Name/Relationship (Type, Print)
Ira Tomblin (HUSBAND) | | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
341 Homberg Avenue Essex, Md. 21221 | | | |
| 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Holly Hill Mem. Gardens | | Date
5/28/1996 | | 20c. Location - City or Town, State
Baltimore Co., Md. |
| 21. Signature of Funeral Service Licensee
 | | | | | 22. Name and Address of Facility
Brzezinski Funeral Home P.A.
1407 Old Eastern Ave. Essex, Md. 21221 | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. Myocardial Infarction
Due to (or as a consequence of):
b. Ischemic Heart Disease
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.
Approximate Interval Between Onset and Death
4 hours | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Esophageal Cancer
Chronic Obstructive Pulmonary Disease
Aspiration Pneumonia | | | | | | | | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one)
Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation
<input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined
<input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input type="checkbox"/> No |
| | | | | 28d. Describe how Injury occurred | | 28e. Location (Street and Number or Rural Route Number, City or Town, State) | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | 29b. Signature and title of certifier
 | | 29c. License number
D46656 | | |
| | | | | 29d. Date signed (Month, Day, Year)
5/25/96 | | | | |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)
Dr. Samer Eldeiry 9000 Franklin Square Drive Baltimore, Maryland 21237 | | | | | | | | |
| 31. Date filed (Month, Day, Year)
MAY 28 1996 | | | | 32. Registrar's Signature
 | | | | |

Baltimore, Maryland 21215-0020

permitted. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

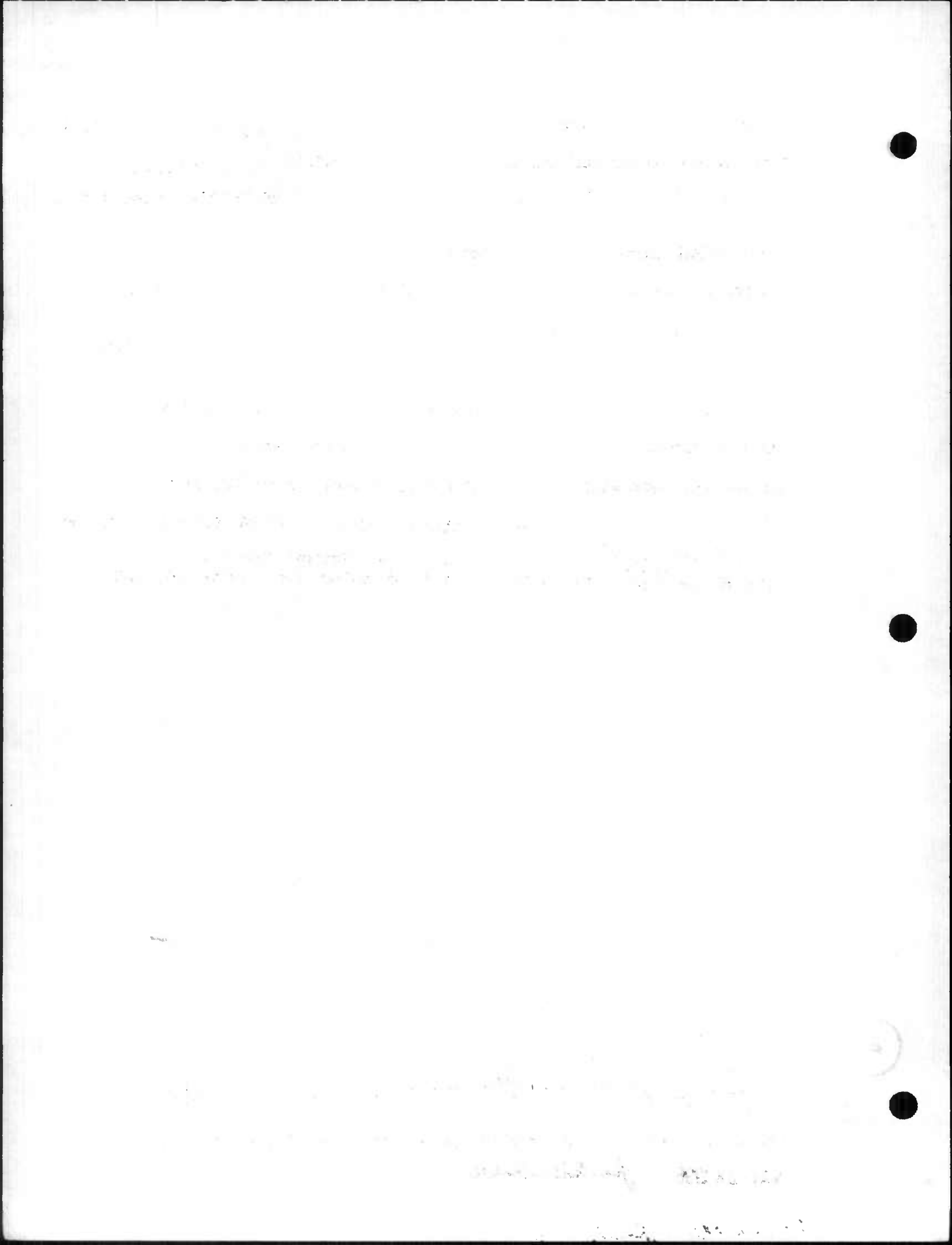
Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 15686

Certificate of Death

Reg. No.

| | | | | | | | | | |
|--|--|--|---|---|--|--|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
ERICA JACKSON THOMAS | | | | 2. Date of Death
Month Day Year
May 19, 1996 | | 3. Time of Death
4:55 AM | | |
| | 4a. Facility Name (If not institution, give street and number)
WASHINGTON COUNTY HOSPITAL | | | | 4b. City, Town, or Location of Death
HAGERSTOWN | | 4c. County of Death
WASHINGTON | | |
| Funeral
Director | 5. Social Security Number
236-98-9028 | 6. Sex
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)
25 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth (Month, Day, Year)
AUG. 2, 1970 | | 9. Birthplace (State or Foreign Country)
WEST VIRGINIA | |
| | Usual Residence of Decedent | | | | | | | | |
| To Be Completed by Funeral Director | 10a. State
MD | 10b. County
WASHINGTON | | 10c. City, Town or Location
HAGERSTOWN | | | 10d. Inside City Limits
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | |
| | 10e. Street and Number
407 JEFFERSON STREET | | | | 10f. Zip Code
21740 | | 10g. Citizen of What Country?
U. S. A. | | |
| | 11. Marital Status
1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: BLACK | | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (1-4 or 5+) 2 | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
COSMETOLOGIST | | | 16b. Kind of Business/Industry
COSMETOLOGY | | |
| | 17. Father's Name (First, Middle, Last)
JOE BRANSON | | | | 18. Mother's Name (First, Middle, Maiden Surname)
LINDA MASON | | | | |
| | 19a. Informant's Name/Relationship (Type, Print)
LINDA THOMAS | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
105 WESTERN AVENUE, MARTINSBURG, WV 25401 | | | | |
| | 20a. Method of Disposition
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
MT. HOPE CEMETERY | | Date
5/23/96 | | 20c. Location - City or Town, State
MARTINSBURG, WV | | |
| | 21. Signature of Funeral Service Licensee
Charles M. Brown | | | | 22. Name and Address of Facility
BROWN FUNERAL HOME, 327 W. KING STREET
PO BOX 821, MARTINSBURG, WV 25401 | | | | |
| | 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | | Approximate Interval Between Onset and Death |
| | Immediate Cause (Final disease or condition resulting in death)
a. Lymphoma
Due to (or as a consequence of):
b. Acquired Immunodeficiency Syndrome
Due to (or as a consequence of):
c. Human Immunodeficiency Virus
Due to (or as a consequence of):
d. | | | | | | | | 8 weeks
3 years
3 years |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Mycobacterium Avium-intracellular
Disseminated infection | | | | | | | | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown
24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one)
Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide
5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| 29a. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | |
| 29b. Signature and title of certifier
Nora J. Delgado | | | | 29c. License number
026523 | | 29d. Date signed (Month, Day, Year)
5/20/96 | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
11110 Medical Camps Road, HAGERSTOWN MD 21742 | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
MAY 28 1996 | | | | 32. Registrar's Signature
Julia Burton-Russell | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

THE STATE OF TEXAS

COUNTY OF DALLAS

Know all men by these presents

that I, the undersigned

do hereby certify that

the within and foregoing

is a true and correct

copy

of the original

filed in my office

this 1st day of

the month of

19

at the City of

Dallas, Texas

Witness my hand and seal

this 1st day of

19

at

the

County of

Dallas

State of Texas

Notary Public

My commission expires

the 1st day of

Notary Public

My commission expires

the 1st day of

19

at

the City of

Dallas

Texas

Notary Public

My commission expires

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 15687

Certificate of Death

Reg. No.

| | | | | | | | | |
|--|--|-----------------------------------|---|--|---|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
WILLIAM ALBERT WILSON | | | | 2. Date of Death
Month Day Year
MAY 26, 1996 | | 3. Time of Death
10:25 PM | |
| | 4a. Facility Name (If not institution, give street and number)
4625 MARY AVE. | | | | 4b. City, Town, or Location of Death
BALTIMORE | | 4c. County of Death
N/A | |
| Funeral
Director | 5. Social Security Number
212-09-3447 | | 6. Sex
1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 7. Age (In yrs. last birthday)
76 Yrs. | | 8. Date of Birth (Month, Day, Year)
March 17, 1920 | |
| | 9. Birthplace (State or Foreign Country)
Maryland | | 10. Usual Residence of Decedent
10a. State: Maryland 10b. County: N/A 10c. City, Town or Location: Baltimore 10d. Inside City Limits: 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: WW II | |
| To Be Completed by Funeral Director | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: White | | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12): 10 Collegia (1-4 or 5+) | | 16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Manager | |
| | 17. Father's Name (First, Middle, Last)
William P. Wilson | | 18. Mother's Name (First, Middle, Maiden Summa)
Reba Mullinix | | 19. Informant's Name/Relationship (Type, Print)
Mrs. Dorothy E. Wilson/ Wife | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
4625 Mary Avenue Baltimore, Maryland 21206 | |
| | 20a. Method of Disposition
1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Hilltop Service Corporation | | 20c. Location - City or Town, State
Towson, Maryland | | 20d. Date
5/28/96 | |
| | 21. Signature of Funeral Service Licensee
Mark T. Zavoyna | | 22. Name and Address of Facility
Leonard J. Ruck, Inc.
5305 Harford Road Baltimore, Md. 21214 | | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Arteriosclerotic Cardiovascular Disease
Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | Approximate Interval Between Onset and Death | |
| Physician
/Medical
Examiner | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Emphysema | | | | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown | | | |
| | 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | |
| | 25. Was case referred to medical examiner?
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| | 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28d. Describe how injury occurred | | 28e. Location (Street and Number or Rural Route Number, City or Town, State) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | |
| Medical Certification: To Be Completed by Physician/Medical Examiner | 29a. Certifier (Check only one)
1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| | 29b. Signature and title of certifier
Donald G. Wright MD | | | | 29c. License number
O.C.M.E. | | 29d. Date signed (Month, Day, Year)
MAY 27, 1996 | |
| | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Donald G. Wright M.D. 111 Penn Street, Baltimore, Maryland 21201 | | | | | | | |
| State Registrar | 31. Date filed (Month, Day, Year)
MAY 28 1996 | | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

3+1

96 15688

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|--|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
<i>Charles William Wilson</i> | | | | 2. DATE OF DEATH
MONTH <i>May</i> DAY <i>21</i> YEAR <i>1996</i> | | 3. TIME OF DEATH
<i>4:04 p.</i> | |
| 4. SOCIAL SECURITY NUMBER
<i>233-36-7952</i> | | 5. SEX
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | 6. AGE (In yrs. last birthday)
<i>68</i> YRS. | IF UNDER 1 YEAR
MONTHS <input type="checkbox"/> DAYS <input type="checkbox"/> | IF UNDER 24 HRS.
HOURS <input type="checkbox"/> MIN. <input type="checkbox"/> | 7. DATE OF BIRTH (Month, Day, Year)
<i>Aug. 3, 1927</i> | |
| 8. BIRTHPLACE (State or Foreign Country)
<i>West Virginia</i> | | | | 9a. FACILITY NAME (If not institution, give street and number)
<i>243 Trappe Road</i> | | 9b. CITY, TOWN OR LOCATION OF DEATH
<i>Dundalk</i> | |
| 9c. COUNTY OF DEATH
<i>Baltimore</i> | | | | 10a. STATE
<i>Maryland</i> | | 10b. COUNTY
<i>Baltimore</i> | |
| 10c. CITY, TOWN OR LOCATION
<i>Dundalk</i> | | | | 10d. INSIDE CITY LIMITS?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 10e. STREET AND NUMBER
<i>243 Trappe Road</i> | |
| 10f. ZIP CODE
<i>21222</i> | | | | 10g. CITIZEN OF WHAT COUNTRY?
<i>United States</i> | | 11. MARITAL STATUS
<input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO
IF YES, GIVE WAR OR DATES <i>WW II</i> | | | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify: <i>White</i> | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12) <i>7 years</i>
College (14 or 5 +) | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
<i>Steelworker</i> | | 16b. KIND OF BUSINESS/INDUSTRY
<i>Steel</i> | |
| 17. FATHER'S NAME (First, Middle, Last)
<i>William M. Wilson</i> | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
<i>Daisy Lilly Ayers</i> | | | |
| 19a. INFORMANT'S NAME (Type/Print)
<i>Sandy L. Wilson (Daughter)</i> | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
<i>243 Trappe Road Dundalk, Maryland 21222</i> | | | |
| 20a. METHOD OF DISPOSITION
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
<i>Glen Haven Cemetery 5/25/96</i> | | 20c. LOCATION — City or Town, State
<i>Glen Burnie, Md.</i> | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
<i>[Signature]</i> | | | | 22. NAME AND ADDRESS OF FACILITY
<i>Duda-Ruck Funeral Home of Dundalk, Inc.
7922 Wise Avenue Dundalk, Maryland 21222</i> | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>CHRONIC OBSTRUCTIVE PULMONARY DISEASE</i> | | | | | | | |
| DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | |
| b. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| c. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| d. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
<i>LUNG CANCER</i> | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | | | | |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | | | | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA
OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | |
| 27. MANNER OF DEATH
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation
<input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Could not be determined | | | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
<i>M</i> | |
| 28c. INJURY AT WORK?
<input type="checkbox"/> YES <input type="checkbox"/> NO | | | | 28d. DESCRIBE HOW INJURY OCCURRED | | | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one)
<input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
<i>[Signature]</i> | | | | 29c. LICENSE NUMBER
<i>D38409</i> | | 29d. DATE SIGNED (Month, Day, Year)
<i>5/22/96</i> | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
<i>William Simon, 4940 Eastern Ave, Balt 21224</i> | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
<i>MAY 28 1996</i> | | | | | | | |

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

6+1

3

Division of Vital Records, P.O. Box 68760,
Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Physician /Medical Examiner

Physician /Medical Examiner

State Registrar

1. Decedent's Name (First, Middle, Last)
JOSEPH WARD

2. Date of Death
Month **MAY** Day **22nd** Year **1996**

3. Time of Death
5:25 AM

4a. Facility Name (If not institution, give street and number)
Church Hospital

4b. City, Town, or Location of Death
Baltimore

4c. County of Death
N/A

5. Social Security Number
246-16-2036

6. Sex
☒ M ☐ F

7. Age (In yrs. last birthday)
85 Yrs.

8. Date of Birth (Month, Day, Year)
Jan. 4, 1911

9. Birthplace (State or Foreign Country)
N. Carolina

10a. State
Maryland

10b. County
N/A

10c. City, Town or Location
Baltimore

10d. Inside City Limits
☒ Yes ☐ No

10e. Street and Number
1835 N. Aisquith Street

10f. Zip Code
21202

10g. Citizen of What Country?
United States

11. Marital Status
☐ Never Married ☐ Married
☒ Widowed ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?
☐ Yes ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.
Specify: **Black**

15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) **3rd** College (1-4or 5+) **-**

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Laborer

16b. Kind of Business/Industry
Various Trades

17. Father's Name (First, Middle, Last)
John Ward

18. Mother's Name (First, Middle, Maiden Sumame)
Dorothy Fleming

19a. Informant's Name/Relationship (Type, Print)
Yvonne Barnes

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
2320 Koko Lane, Baltimore, Maryland 21216

20a. Method of Disposition
☒ Burial ☐ Cremation ☐ Removal from State
☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)
King Memorial Park Cem. 5-28-96

20c. Location - City or Town, State
Randallstown, MD

21. Signature of Funeral Service Licensee
Symette K. Jones

22. Name and Address of Facility
**March Funeral Home
1101 E. North Avenue, Baltimore, MD 21202**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
CHRONIC RENAL FAILURE

Approximate Interval Between Onset and Death
One year

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?
☐ Yes ☒ No ☐ Probably ☐ Unknown

24a. Was an autopsy performed?
☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?
☐ Yes ☒ No

25. Was case referred to medical examiner?
☐ Yes ☒ No

Hospital: ☒ Inpatient ☐ ER/Outpatient ☐ DOA Other: ☐ Nursing Home ☐ Residence ☐ Other (Specify)

26. Place of Death (Check only one)

27. Manner of Death
☒ Natural ☐ Pending Investigation
☐ Accident ☐ Could not be determined
☐ Suicide ☐ Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury
M

28c. Injury at Work?
☐ Yes ☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and Title of certifier
Adoro MD

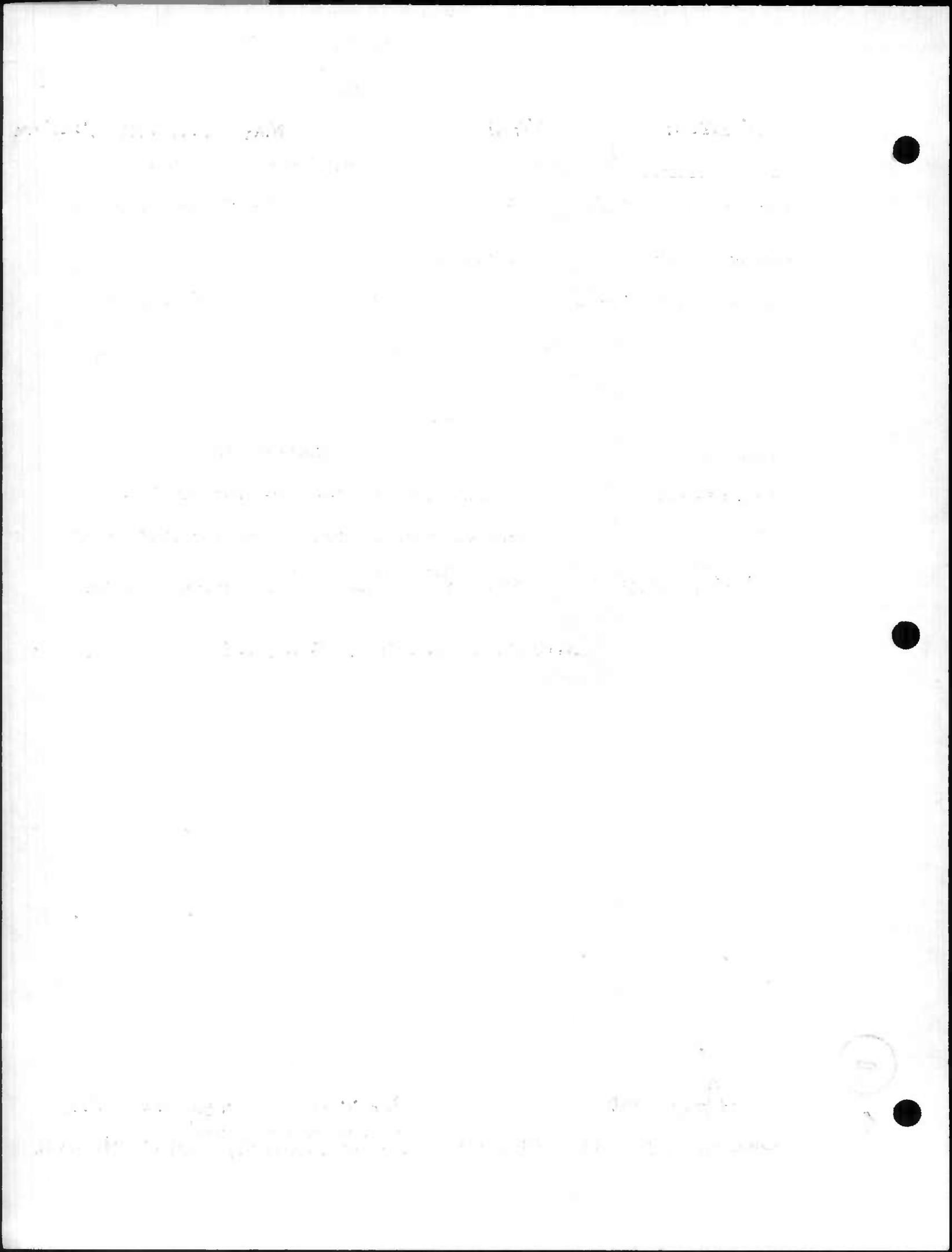
29c. License number
346530

29d. Date signed (Month, Day, Year)
MAY 22nd 1996

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
**CLARENCE SARKOBE - Adoro MD
100 N BROADWAY, BALT MD 21231.**

31. Date filed (Month, Day, Year)
MAY 28 1996

32. Registrar's Signature
Jaki Shuler-Randall



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene
Certificate of Death

96 15690

Reg. No.

| | | | | | | | | |
|---|---|---|--|--|---|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
CHARLENE REID WASHINGTON | | | | 2. Date of Death
Month MAY Day 23 Year 1996 | | 3. Time of Death
2241 pm | |
| | 4a. Facility Name (If not institution, give street and number)
UNIVERSITY OF MARYLAND | | | | 4b. City, Town, or Location of Death
BALTIMORE | | 4c. County of Death
n/a | |
| Funeral
Director | 5. Social Security Number
244-37-5533 | | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)
31 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth (Month, Day, Year)
NOV. 20, 1964 | 9. Birthplace (State or Foreign Country)
WILSON CO., NC |
| | Usual Residence of Decedent | | | | | | | |
| 10a. State
MD | | 10b. County
n/a | | 10c. City, Town or Location
BALTIMORE GLEN BURNIE | | | 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 10e. Street and Number
8085 BUDDING BRANCH ROAD apt. T4 | | | | 10f. Zip Code
21061 | | 10g. Citizen of What Country?
UNITED STATES | | |
| 11. Marital Status
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: BLACK | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) - College (1-4 or 5+) 2 years | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
TELEPHONE OPERATOR | | 16b. Kind of Business/Industry
411- FORT MEADE | | |
| 17. Father's Name (First, Middle, Last)
JAMES REID | | | | 18. Mother's Name (First, Middle, Maiden Summa)
HERLENE SMITH (REID) | | | | |
| 19a. Instantant's Name/Relationship (Type, Print)
JAMES EDDIE REID / ROBERT WASHINGTON | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
P.O. BOX 591 FREEMONT, NC 27830 | | | | |
| 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
ship Data FREEMONT CEMETERY 5-24 | | 20c. Location - City or Town, State
FREEMONT, N. CAROLINA | | | | |
| 21. Signature of Funeral Service Licensee
 | | | | 22. Name and Address of Facility
WM. C. MARCH FH.-1101 E. NORH AVENUE BALTO, MD | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. REJECTION OF HEART TRANSPLANT
Due to (or as a consequence of):
b. Post Partum CARDIOMYOPATHY
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d. | | | | | | | | Approximate Interval Between Onset and Death |
| Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | |
| | | | | | | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death
<input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how Injury occurred |
| | | 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the causa(s) and manner stated. | | 29b. Signature and Title of certifier
 | | 29c. License number
D46015 | | 29d. Date signed (Month, Day, Year)
MAY 23 1996 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
DOUGLAS WATKINS, DEPT OF CRIMINAL JUSTICE, 22 S. GREENE ST., BALTIMORE, MD. | | | | | | | | |
| 31. Date filed (Month, Day, Year)
MAY 28 1996 | | 32. Registrar's Signature
 | | | | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 15691

| | | | | | | | | | |
|--|--|---|--|--|---|--|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Edna Lee Wagner | | | | 2. Date of Death
Month Day Year
MAY 23 1996 | | 3. Time of Death
4:05 PM | | |
| | 4e. Facility Name (If not institution, give street and number)
Genesis Eldercare - Cromwell | | | | 4b. City, Town, or Location of Death
Baltimore | | 4c. County of Death
Baltimore | | |
| Funeral
Director | 5. Social Security Number
220-01-1360 | | 6. Sex
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday)
79 Yrs. | | 8. Date of Birth (Month, Day, Year)
June 12, 1916 | | |
| | 9. Birthplace (State or Foreign Country)
Virginia | | 10a. State
Maryland | | 10b. County
Baltimore | | 10c. City, Town or Location
Parkville | | |
| Usual Residence of Decedent | | 10d. Inside City Limits
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 10e. Street and Number
2810 Garnet Road | | 10f. Zip Code
21234 | | 10g. Citizen of What Country?
USA | |
| 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: White | | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 7
College (1-4 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Seamstress | | 16b. Kind of Business/Industry
Clothing Industry | | | | | |
| 17. Father's Name (First, Middle, Last)
Joseph Cruely | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Daisy Virginia Spriggs | | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
Betsy Wagner Hertzog / daughter | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
2810 Garnet Road Parkville, MD 21234 | | | | | |
| 20a. Method of Disposition
1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Metro Crematory, Inc. | | 20c. Date
05/24/96 | | 20d. Location - City or Town, State
Baltimore, MD | | | |
| 21. Signature of Funeral Service Licensee Dawn F. McDonald | | | | 22. Name and Address of Facility
Cremation Society of Maryland, Inc.
299 Frederick Rd. Baltimore, MD 21228 | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. <u>Congestive Heart Failure</u>
Due to (or as a consequence of):
b. <u>Arteriosclerotic coronary artery disease</u>
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | | Approximate Interval Between Onset and Death | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown | |
| | | | | | | | | 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | |
| | | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide
5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | |
| | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier
Marian Kamler MD | | | | | | | |
| | | 29c. License number
D21022 | | | | 29d. Date signed (Month, Day, Year)
May 24, 1996 | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
H. Kuntzowski MD 8604 HAMFORD 21234 | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
MAY 28 1996 | | 32. Date of Death
MAY 23 1996 | | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 15692

Certificate of Death

Reg. No.

| | | | | | | | | | | |
|--|---|---|---|--|---|---|---|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
LEROY WHITE SR. | | | | 2. Date of Death
Month Day Year
MAY 22, 1996 | | 3. Time of Death
4:40 PM. | | | |
| | 4a. Facility Name (If not institution, give street and number)
SINAI HOSPITAL | | | | 4b. City, Town, or Location of Death
BALTIMORE | | 4c. County of Death
N/A | | | |
| Funeral
Director | 5. Social Security Number
251-60-2016 | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)
64 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth (Month, Day, Year)
DEC 1, 1931 | | 9. Birthplace (State or Foreign Country)
SOUTH CAROLINA | |
| | Usual Residence of Decedent | | | | | | | | | |
| To Be Completed by Funeral Director | 10a. State
MD. | | 10b. County
N/A | | 10c. City, Town or Location
BALTIMORE | | | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | |
| | 10e. Street and Number
2106 WEST SARATOGA STREET | | | | 10f. Zip Code
21223 | | 10g. Citizen of What Country?
USA | | | |
| | 11. Marital Status
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: BLACK | | | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12TH
College (1-4 or 5+) College (1-4 or 5+) | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
MEAT SMOKER | | | 16b. Kind of Business/Industry
MEAT PACKING | | | |
| | 17. Father's Name (First, Middle, Last)
JOSEPH WHITE | | | | 18. Mother's Name (First, Middle, Maiden Surname)
ROSA McFADDEN | | | | | |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print)
ETHEL M. WHITE (WIFE) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
2106 W. SARATOGA ST. BALTO, MD. 21223 | | | | | |
| | 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
McFADDEN CEMETERY | | Date
5/28/96 | | 20c. Location - City or Town, State
OLANTA, SC. | | | |
| | 21. Signature of Funeral Service Licensee
 | | | | 22. Name and Address of Facility
CAPLE FUNERAL SERVICE
5502 Winner Ave Balto, MD. 21215 | | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. RUPTURED THORACIC AORTIC ANEURYSM
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of): | | | | | | | | | Approximate Interval Between Onset and Death |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | | |
| | | | | | | 24a. Was an autopsy performed?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | |
| 25. Was case referred to medical examiner?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | | |
| 29a. Certifier (Check only one)
<input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier
 | | | | 29c. License number
O.C.M.E. | | 29d. Date signed (Month, Day, Year)
MAY 23, 1996 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
MARY ANN B. KOWALCZYK 111 Penn Street, Baltimore, Maryland 21201 | | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
MAY 28 1996 | | | | | 32. Registrar's Signature
 | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

28-2701-510

asp

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 15693

Certificate of Death

Reg. No.

| | | | | | | | | | | |
|--|--|---|---|--------------------------------|--|--|--|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
TYRONE MAURICE WOODS | | | | 2. Date of Death
Month Day Year
MAY 18 1996 | | 3. Time of Death
3:17 A | | | |
| | 4a. Facility Name (If not institution, give street and number)
4719 OLD YORK RD. | | | | 4b. City, Town, or Location of Death
BALTIMORE | | 4c. County of Death
N/A | | | |
| Funeral
Director | 5. Social Security Number
216-86-3934 | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)
26 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth (Month, Day, Year)
OCT 12, 1969 | | 9. Birthplace (State or Foreign Country)
MARYLAND | | |
| | Usual Residence of Decedent | | | | | | | | | |
| To Be Completed by Funeral Director | 10a. State
MD. | 10b. County
N/A | 10c. City, Town or Location
BALTIMORE | | | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | |
| | 10e. Street and Number
4719 OLD YORK ROAD | | | 10f. Zip Code
21212 | | 10g. Citizen of What Country?
USA | | | | |
| | 11. Marital Status
<input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: BLACK | | | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 10th | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
DISHWASHER | | 16b. Kind of Business/Industry
RESTAURANT | | | | | |
| | 17. Father's Name (First, Middle, Last)
JAMES BEST | | | | 18. Mother's Name (First, Middle, Maiden Surname)
IDA WOODS | | | | | |
| | 19a. Informant's Name/Relationship (Type, Print)
IDA WOODS (MOTHER) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
4719 OLD YORK ROAD BALTIMORE, MD. 21212 | | | | | |
| | 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
SACRED HEART | | 20c. Location - City or Town, State
DUNDALK, MARYLAND | | 20d. Date
5/23/96 | | | |
| | 21. Signature of Funeral Service Licensee
 | | | | 22. Name and Address of Facility
CAPLE FUNERAL SERVICE
5502 WINNER AVENUE BALTIMORE, MD 21215 | | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. <u>Sub wound of chest</u>
Due to (or as a consequence of):

b.
Due to (or as a consequence of):

c.
Due to (or as a consequence of):

d.
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | | Approximate Interval Between Onset and Death | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | |
| | | | | | | 24a. Was an autopsy performed?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | |
| 25. Was case referred to medical examiner?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | | |
| 27. Manner of Death
<input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide
<input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year)
5-18-96 | | 28b. Time of Injury
0310 M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred
Subject stabbed | | |
| | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
Home | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State)
4719 Old York Rd. Balto. | | | | |
| 29a. Certifier (Check only one)
<input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier
 | | 29c. License number
O.C.M.E | | 29d. Date signed (Month, Day, Year)
MAY 18, 1996 | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
111 Penn Street, Baltimore, Maryland 21201 | | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
MAY 28 1996 | | 32. Registrar's Signature
 | | | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours of the death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 15694

Certificate of Death

Item: 4a, per F.H. G-735 5/28/96 reb

Reg. No.

| | | | | | | |
|--|---|--|---|---|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
MICHAEL J. WAGNER | | 2. Date of Death
Month Day Year
MAY 22 1996 | | 3. Time of Death
11:15 A | |
| | 4a. Facility Name (If not institution, give street and number)
LIBERTY RESERVOIR RESERVOIR | | 4b. City, Town, or Location of Death
SYKESVILLE | | 4c. County of Death
CARROLL | |
| Funeral
Director | 5. Social Security Number
484-62-6963 | | 8. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)
45 Yrs. | 9. Birthplace (State or Foreign Country)
Iowa | |
| | Usual Residence of Decedent
10a. State
Maryland | | 10b. County
Carroll | | 10c. City, Town or Location
Sykesville | |
| To Be Completed by Funeral Director | 10e. Street and Number
620 Shimmering Run Court | | 10f. Zip Code
21784 | | 10g. Citizen of What Country?
USA | |
| | 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | |
| | 14. Race - American Indian, Black, White, etc.
Specify: White | | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) College (1-4or 5+) 5+ | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Compensation Analyst | |
| | 16b. Kind of Business/Industry
Corporate Industry | | 17. Father's Name (First, Middle, Last)
Joseph Francis Wagner | | 18. Mother's Name (First, Middle, Maiden Surname)
Monica McAndrew | |
| | 19a. Informant's Name/Relationship (Type, Print)
Mary Jane Elinson/Sister | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
4637 Revere Dr. Virginia Beach, VA 23456 | | | |
| | 20a. Method of Disposition
1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Metro Crematory, Inc. 5/24/96 | | 20c. Location - City or Town, State
Baltimore, MD | |
| | 21. Signature of Funeral Service Licensee
Dawn F. McDonald | | 22. Name and Address of Facility
Cremation Society of Maryland, Inc.
299 Frederick Rd. Baltimore, MD 21228 | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
Immediate Cause (Final disease or condition resulting in death)
a. CONTACT SHOTGUN OF CHEST
Due to (or as a consequence of):
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | |
| | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | | | |
| | 24a. Was an autopsy performed?
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death?
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | | |
| Medical Certification: To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner?
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input checked="" type="checkbox"/> Other (Specify) SCENE | | | |
| | 27. Manner of Death
1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation
2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined
3 <input checked="" type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. Date of injury (Month, Day Year)
FORD 5-22-96 | | 28b. Time of injury
9 38 M | |
| | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred
GUNSHOT SELF | | | |
| | 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)
CARE | | 28f. Location (Street and Number or Rural Route Number, City or Town, State)
LIBERTY RESERVOIR CARROLL | | | |
| State
Registrar | 29a. Certifier (Check only one)
1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | |
| | 29b. Signature and title of certifier
Margaret Presbrey | | 29c. License number
O.C.M.E | | 29d. Date signed (Month, Day, Year)
MAY 23, 1996 | |
| | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
MADONNA A. KOREN MD 111 Penn Street, Baltimore, Maryland 21201 | | | | | |
| 31. Date filed (Month, Day, Year)
MAY 28 1996 | | | | | | |
| 32. Registrar's Signature
John A. ... | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filed by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 15695

Certificate of Death

Reg. No.

| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|--|---|--|---|--|--|--|--|---|---|--|---|------------------------------------|--|--|--|--|--|--|--|--|----------------------------------|--|--|--|--|--|--|--|--|-----------------------------------|--|--|--|--|--|--|--|--|----------------------------------|--|--|--|--|--|--|--|--|--|---------------------------------|--|--|--|--|--|--|--|--|----------------------------------|--|--|--|--|--|--|--|--|----|--|--|--|--|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Alice WINGATE | | | | | | 2. Date of Death
Month Day Year
May 25, 1996 | | 3. Time of Death
4:47 am | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | 4a. Facility Name (If not institution, give street and number)
Franklin Square Hospital | | | | | | 4b. City, Town, or Location of Death
Baltimore | | 4c. County of Death
Baltimore County | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Funeral
Director | 5. Social Security Number
212-20-8745 | | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday)
73 Yrs. | | 8. Date of Birth (Month, Day, Year)
Aug. 16, 1922 | | 9. Birthplace (State or Foreign Country)
Maryland | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | Usual Residence of Decedent | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| To Be Completed by Funeral Director | 10a. State
Maryland | | 10b. County
Baltimore | | 10c. City, Town or Location
Baltimore | | | | 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | 10e. Street and Number
7941 Lynch Road | | | | 10f. Zip Code
21222 | | 10g. Citizen of What Country?
U.S.A. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | 11. Marital Status
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc.
Specify: White | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 8th College (1-4or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Cashier | | | 16b. Kind of Business/Industry
Retail Sales | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | 17. Father's Name (First, Middle, Last)
George D. Edmondson | | | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Bessie Belle Clements | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | 19a. Informant's Name/Relationship (Type, Print)
Pete Rafalides, Pers. Repr. | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1239 S. 48th Street, Baltimore, Md. 21222 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Sacred Heart of Jesus Cem. 5-29 | | Date | | 20c. Location - City or Town, State
Baltimore, Md. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | 21. Signature of Funeral Service Licensee
 | | | | 22. Name and Address of Facility
Matthews Funeral Home
3021 Eastern Ave., Baltimore, Md. 21224 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | <table border="0"> <tr> <td rowspan="4">Immediate Cause (Final disease or condition resulting in death)</td> <td colspan="9">a. Congestive Heart Failure</td> </tr> <tr> <td colspan="9">Due to (or as a consequence of):</td> </tr> <tr> <td colspan="9">b. Coronary Artery Disease</td> </tr> <tr> <td colspan="9">Due to (or as a consequence of):</td> </tr> <tr> <td rowspan="2">Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last</td> <td colspan="9">c. Myocardial Infarction</td> </tr> <tr> <td colspan="9">Due to (or as a consequence of):</td> </tr> <tr> <td colspan="9">d.</td> </tr> </table> | | | | | | | | | | Immediate Cause (Final disease or condition resulting in death) | a. Congestive Heart Failure | | | | | | | | | Due to (or as a consequence of): | | | | | | | | | b. Coronary Artery Disease | | | | | | | | | Due to (or as a consequence of): | | | | | | | | | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | c. Myocardial Infarction | | | | | | | | | Due to (or as a consequence of): | | | | | | | | | d. | | | | | | | |
| Immediate Cause (Final disease or condition resulting in death) | a. Congestive Heart Failure | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | Due to (or as a consequence of): | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | b. Coronary Artery Disease | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | Due to (or as a consequence of): | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | c. Myocardial Infarction | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | Due to (or as a consequence of): | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| d. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Physician
/Medical
Examiner | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| Medical Certification: To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation
<input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined
<input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input type="checkbox"/> No | | 28d. Describe how injury occurred | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| State Registrar | 29b. Signature and title of certifier

Selwyn E. Mahon M.D. | | | | 29c. License number
D47765 | | 29d. Date signed (Month, Day, Year)
5/25/96 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Selwyn Mahon M.D. 6603 Evanston Street Forestville, Maryland 20747 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
MAY 28 1996 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 32. Registrar's Signature
 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

at the time of the
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

96 15696

Reg. No.

| | | | | | | | | |
|---|--|---|--|--|---|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Arthur Lee Zimmerman | | | | 2. Date of Death
Month MAY Day 25 Year 1996 | | 3. Time of Death
6:46 PM | |
| | 4e. Facility Name (If not institution, give street and number)
Hopkins Bay View Hospital | | | | 4b. City, Town, or Location of Death
Baltimore | | 4c. County of Death
N/A | |
| Funeral
Director | 5. Social Security Number
220 30 1803 | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)
62 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth (Month, Day, Year)
11 06 33 | 9. Birthplace (State or Foreign Country)
Maryland |
| | Usual Residence of Decedent | | | | | | | |
| 10a. State
Md. | | 10b. County
N/A | | 10c. City, Town or Location
Baltimore | | | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | |
| 10e. Street and Number
1552 Elrino Street | | | | 10f. Zip Code
21224 | | 10g. Citizen of What Country?
USA | | |
| 11. Marital Status
<input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
If Yes, Give Year or Dates 1954-1956 | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify White | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 8 College (1-4or 5+) | | | | 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Carpenter | | 16b. Kind of Business/Industry
Construction | | |
| 17. Father's Name (First, Middle, Last)
Hiram Zimmerman | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Blanche Harmon | | | | |
| 19e. Informant's Name/Relationship (Type, Print)
Ruth E. Zimmerman, Sister | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1552 Elrino St. Balto., Md. 21224 | | | | |
| 20e. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Oak Lawn Cemetery | | Date
5-30-96 | | 20c. Location - City or Town, State
Eastwood, Md. | | |
| 21. Signature of Funeral Service Licensee
Charles S. Zeiler | | | | 22. Name and Address of Facility
Charles S. Zeiler & Son Inc.
6224 Eastern Ave. Balto., Md. | | | | |
| 23a. Part I. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
SEPSIS
Due to (or as a consequence of):

Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

Due to (or as a consequence of):

Due to (or as a consequence of): | | | | | | | | Approximate Interval Between Onset and Death
8 hours |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | |
| | | | | | | 24e. Was an autopsy performed?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28e. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred |
| | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | |
| 29b. Signature and title of certifier
David P. Stornelli MD | | 29c. License number
D48193 | | 29d. Date signed (Month, Day, Year)
5/25/96 | | | | |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)
David P. Stornelli Johns Hopkins Bayview Medical Center | | | | | | | | |
| 31. Date filed (Month, Day, Year)
MAY 28 1996 | | 32. Registrar's Signature
Wilson-Randall | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 15697

Certificate of Death

Reg. No.

| | | | | | | | | | |
|--|---|---|---|--------------------------------------|--|---|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
MARGARET G. ZLOTORZYNSKI | | | | 2. Date of Death
Month 05 Day 21 Year 96 | | 3. Time of Death
3:55 PM | | |
| | 4a. Facility Name (If not institution, give street and number)
HOPKINS BAY VIEW | | | | 4b. City, Town, or Location of Death
BALTIMORE | | 4c. County of Death
N/A | | |
| Funeral
Director | 5. Social Security Number
218-22-1729 | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)
67 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth (Month, Day, Year)
4-20-29 | | 9. Birthplace (State or Foreign Country)
MARYLAND | |
| | Usual Residence of Decedent | | | | | | | | |
| To Be Completed by Funeral Director | 10a. State
MARYLAND | 10b. County
N/A | 10c. City, Town or Location
BALTIMORE | | | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | |
| | 10e. Street and Number
702 S. RAPPOLA STREET | | | 10f. Zip Code
21224 | | 10g. Citizen of What Country?
USA | | | |
| | 11. Marital Status
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: WHITE | | |
| | 15. Decedent's Education (Specify only highest grade completed)
12 YEARS | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
HOMEMAKER | | 16b. Kind of Business/Industry
OWN HOME | | | | |
| | 17. Father's Name (First, Middle, Last)
BENJAMIN EBERT | | | | 18. Mother's Name (First, Middle, Maiden Sumame)
ANNA (UNKNOWN) | | | | |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print)
MR. ALAN ZLOTORZYNSKI | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
3016 A. OCEAN PINES BERLIN, MARYLAND 21811 | | | | |
| | 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
SACRED HEART OF JESUS CEM | | Data
5-25-96 | | 20c. Location - City or Town, State
BALTO. CO. MD. | | |
| | 21. Signature of Funeral Service Licensee
<i>Charles R. Kaczorowski</i> | | | | 22. Name and Address of Facility
KACZOROWSKI FUNERAL HOME
2525 FLEET ST. BALTO. MD. 21224 | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. Coronary Heart Disease, ACUTE INFARCT
Dua to (or as a consequence of):

b.
Dua to (or as a consequence of):

c.
Dua to (or as a consequence of):

d.
Dua to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last | | | | | | | | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | |
| | | | | | | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 25. Was case referred to medical examiner?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input checked="" type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | |
| | | 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier
<i>[Signature]</i> | | 29c. License number
D33448 | | 29d. Date signed (Month, Day, Year)
5-23-96 | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
2801 Foster Ave
John J. Foster, Jr. | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
MAY 28 1996 | | | | | | | | | |

Baltimore, Maryland 21215-0020

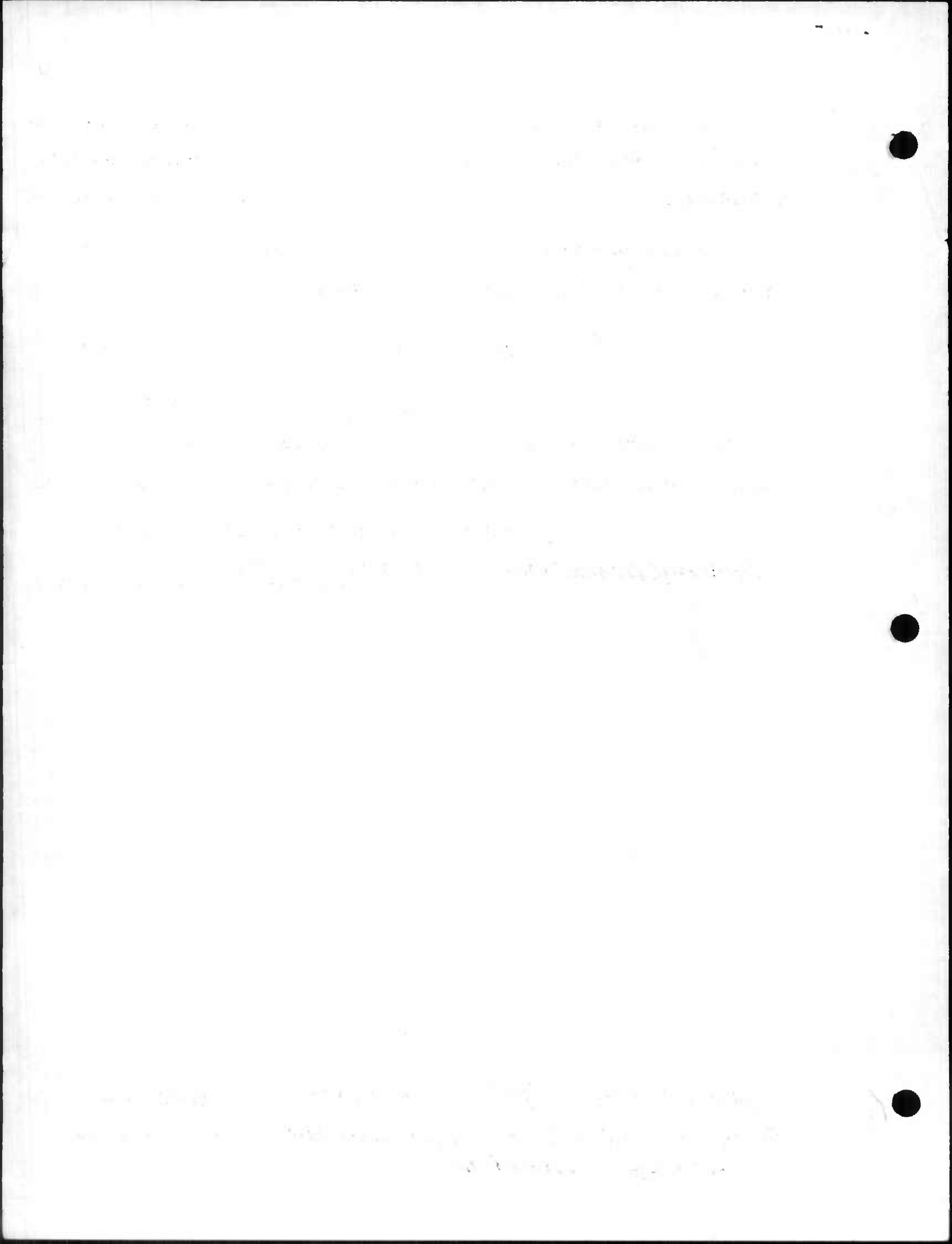
Division of Vital Records, P.O. Box 68760,

State
Registrar

96 15698

Reg. No.

DMMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 15699

Certificate of Death

Reg. No.

| | | | | | | | | |
|-------------------------------------|--|--|---|--|--|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
TONY ABERNATHY | | | | 2. Date of Death
Month Day Year
April 27, 1996 | | 3. Time of Death
7:25 P.M. | |
| | 4a. Facility Name (If not institution, give street and number)
PRINCE GEORGES HOSPITAL CENTER | | | | 4b. City, Town, or Location of Death
Cheverly | | 4c. County of Death
Prince George's | |
| Funeral
Director | 5. Social Security Number
239-18-8373 | | 6. Sex
1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 7. Age (In yrs. last birthday)
80 Yrs. | | 8. Date of Birth (Month, Day, Year)
July 29, 1915 | |
| | 9. Birthplace (State or Foreign Country)
Statesville, NC | | 10. Usual Residence of Decedent
10a. State
10b. County
10c. City, Town or Location
10d. Inside City Limits
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever In U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | |
| To Be Completed by Funeral Director | 13. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Chef | | 14. Kind of Business/Industry
Private | | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12)
11 | | 16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Chef | |
| | 17. Father's Name (First, Middle, Last)
McLain Abernathy | | 18. Mother's Name (First, Middle, Maiden Summa)
Fannie Blanch Lowrence | | 19. Informant's Name/Relationship (Type, Print)
Janet Vernon - Niece | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1005 Arbor Park Place, Mitchellville, MD 20721 | |
| | 20. Method of Disposition
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Lincoln Memorial Cemetery | | 20c. Location - City or Town, State
Suitland, Maryland | | 20d. Date
5/3/96 | |
| | 21. Signature of Funeral Service Licensee
John T. Stewart III | | 22. Name and Address of Facility
STEWART FUNERAL HOME, Inc.
4001 Benning Road, N.E., Washington, D. C. | | 23. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
e. RESPIRATORY FAILURE
Due to (or as a consequence of):
b. Acute renal failure
Due to (or as a consequence of):
c. Septicemia
Due to (or as a consequence of):
d.
Approximate Interval Between Onset and Death
> 4 days. | | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown | |
| | 23a. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Multiple-strokes; CHF; Decub-ules
CAD; Slp-Bil. AKA
He was DNR. | | 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | |
| | 26. Manner of Death
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide
5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 27. Date of Injury (Month, Day, Year) | | 27b. Time of Injury
M | | 27c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| | 27d. Describe how injury occurred | | 27e. Place of Injury - At home, term, street, factory, office building, etc. (Specify) | | 27f. Location (Street and Number or Rural Route Number, City or Town, State) | | 28. Place of Death (Check only one)
Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA
Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify) | |
| | 29e. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier
S. J. Rao, MD | | 29c. License number
D-34525 | | 29d. Date signed (Month, Day, Year)
04-28-96 | |
| | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
S.J. Rao, MD - 4000 Mitchellville Road; #220; Bowie-MD 20716 | | 31. Date filed (Month, Day, Year)
MAY 07 1996 | | 32. Registrar's Signature
Julie Anderson | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 505.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 15700

Certificate of Death

Reg. No.

| | | | | | | | | |
|---|---|--|--|--|---|--|---|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
MILDRED H. BROWN | | | | 2. Date of Death
Month Day Year
MAY 3 1996 | | 3. Time of Death
8:00 am | |
| | 4a. Facility Name (If not institution, give street and number)
1466 CEDAR HURST ROAD | | | | 4b. City, Town, or Location of Death
SHADY SIDE | | 4c. County of Death
ANNE ARUNDEL | |
| Funeral
Director | 5. Social Security Number
216-22-3176 | | 6. Sex
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday)
81 Yrs. | | 8. Date of Birth (Month, Day, Year)
JULY 3 1914 | |
| | 9. Birthplace (State or Foreign Country)
MARYLAND | | 10a. State
MARYLAND | | 10b. County
ANNE ARUNDEL | | 10c. City, Town or Location
SHADY SIDE | |
| To Be Completed by Funeral Director | 10d. Inside City Limits
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | 10e. Street and Number
1451 SHADY REST ROAD | | 10f. Zip Code
20764 | |
| | 10g. Citizen of What Country?
US | | | | 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | |
| To Be Completed by Physician/Medical Examiner | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | | 14. Race - American Indian, Black, White, etc.
Specify: BLACK | | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 11th Collage (1-4or 5+) 0 | |
| | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
NURESE AID | | | | 16b. Kind of Business/Industry
SELF EMPLOYED | | | |
| To Be Completed by Physician/Medical Examiner | 17. Father's Name (First, Middle, Last)
DANTON GROSS | | | | 18. Mother's Name (First, Middle, Maiden Surname)
HELEN CROWNER | | | |
| | 19a. Informant's Name/Relationship (Type, Print)
JOHN FOUNTAIN (SON) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1466 CEDAR HURST RD. SHADY SIDE, MD. 20764 | | | |
| To Be Completed by Physician/Medical Examiner | 20a. Method of Disposition
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
ST. MATTHEWS CHURCH CEME. | | 20c. Location - City or Town, State
SHADY SIDE, MD. | |
| | 21. Signature of Funeral Service Licensee
<i>Larry H. Reese</i> | | | | 22. Name and Address of Facility
WM. REESE & SONS MORTUARY, P.A.
821 WEST ST. ANNAPOLIS, MD. 21401 | | | |
| To Be Completed by Physician/Medical Examiner | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
1. Lung Cancer
2. Cervical Cancer | | | | Approximate Interval Between Onset and Death
12 months
1989 | | | |
| | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | | 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | |
| To Be Completed by Physician/Medical Examiner | 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | |
| | 26. Place of Death (Check only one)
Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify) | | | | 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | | |
| To Be Completed by Physician/Medical Examiner | 28a. Date of injury (Month, Day Year) | | | | 28b. Time of Injury
M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | |
| | 28d. Describe how injury occurred | | | | 28e. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| To Be Completed by Physician/Medical Examiner | 29a. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | 29b. Signature and title of certifier
<i>James C. Roane, M.D.</i> | | | |
| | 29c. License number
210818 | | | | 29d. Date signed (Month, Day, Year)
MAY 7, 1996 | | | |
| To Be Completed by Physician/Medical Examiner | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
James C. Roane, MD 1616 Forest Drive Annapolis 21403 | | | | 31. Data filed (Month, Day, Year)
MAY 10 1996 | | | |
| | 32. Registrar's Signature
<i>John Davidson-Rendell</i> | | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 902-84.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene


96 15701

Certificate of Death

Reg. No.

| | | | | | | | | |
|---|--|---|---|---|--|--|---|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Lurah Frances Bourbon | | | | 2. Date of Death
Month May Day 9 Year 1996 | | 3. Time of Death
8:00 PM | |
| | 4a. Facility Name (If not institution, give street and number)
1109 Lake Heron Drive Apt. A | | | | 4b. City, Town, or Location of Death
Annapolis | | 4c. County of Death
Anne Arundel | |
| Funeral
Director | 5. Social Security Number
423-03-8643 | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)
76 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth (Month, Day, Year)
Nov 20 1919 | 9. Birthplace (State or Foreign Country)
Alabama | |
| | Usual Residence of Decedent | | | | | | | |
| To Be Completed by Funeral Director | 10a. State
MD | 10b. County
Anne Arundel | 10c. City, Town or Location
Annapolis | | | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | |
| | 10e. Street and Number
1109 Lake Heron Drive Apt A | | | 10f. Zip Code
21403 | | 10g. Citizen of What Country?
United States | | |
| | 11. Marital Status
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: White | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (1-4 or 5+) College | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Homemaker | | 16b. Kind of Business/Industry
Home | | | |
| | 17. Father's Name (First, Middle, Last)
Howard V. Jones | | | 18. Mother's Name (First, Middle, Maiden Surname)
Janie Kilgroe | | | | |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print)
James W. McLaurin/Son | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1146 Mainsail Drive Annapolis, Maryland 21403 | | | | |
| | 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Fort Lincoln Cemetery | | Date
May 13 1996 | 20c. Location - City or Town, State
Brentwood, Maryland | | |
| | 21. Signature of Funeral Service Licensee
 | | | 22. Name and Address of Facility
John M. Taylor Funeral Home, Inc.
147 Duke Of Gloucester St. Annapolis, MD 21401 | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. Myocardial infarction suspected
Due to (or as a consequence of):
b. HTN
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | Approximate Interval Between Onset and Death
1 month |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | 23b. Did tobacco use contribute to the cause of death?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |
| 25. Was case referred to medical examiner?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | 5 <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | | |
| | | | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | | |
| | | | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | |
| 29b. Signature and title of certifier
 | | | | 29c. License number
D30718 | | 29d. Date signed (Month, Day, Year)
May 10, 1996 | | |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)
John D. Jackson, M.D. 2003 Medical Pkwy Annapolis, MD 21401 (410-573-1110) | | | | | | | | |
| 31. Date filed (Month, Day, Year)
MAY 10 1996 | | | | 32. Registrar's Signature
 | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

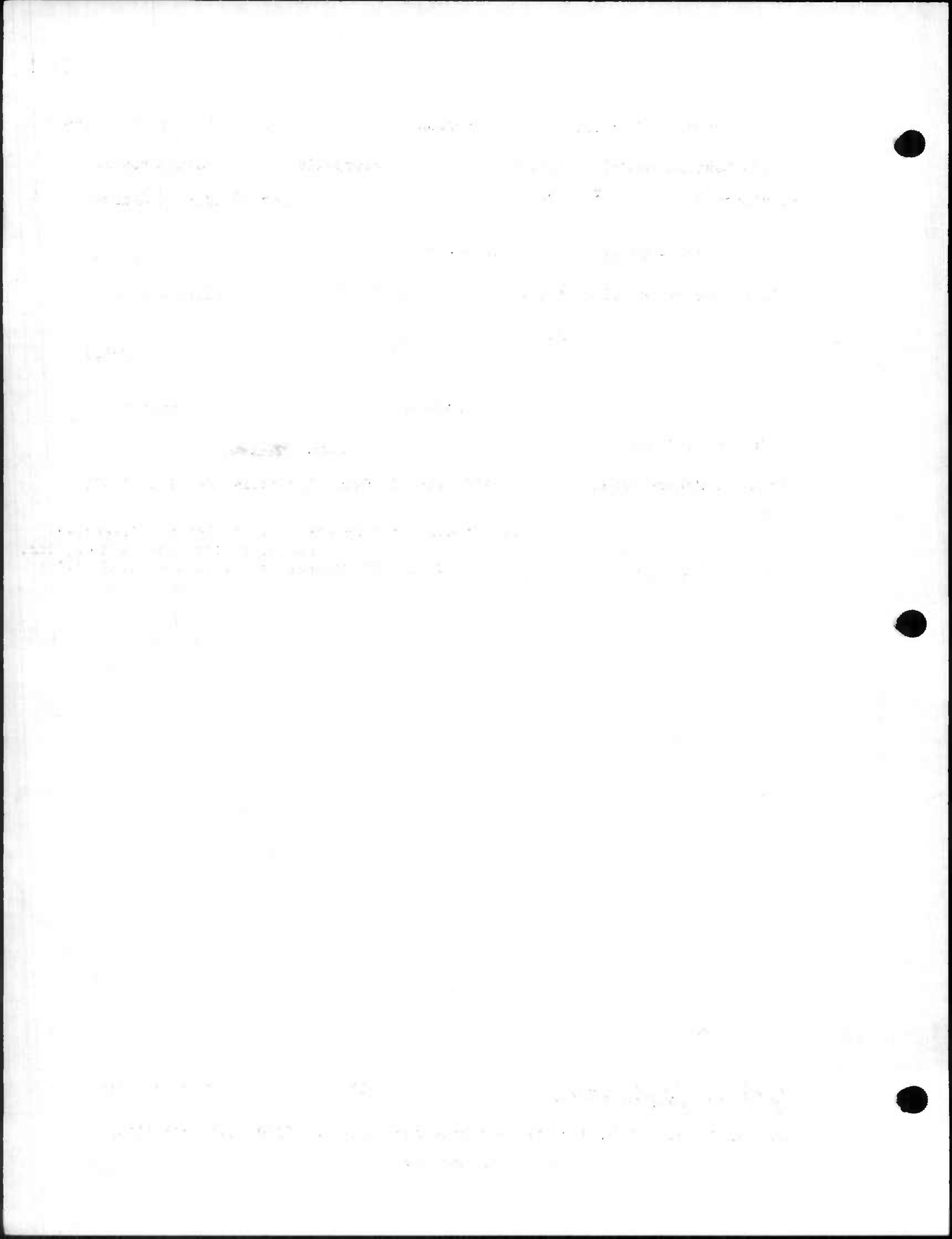
Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar



Amended # 7. P.G.C. 5-15-96 CR

96 15702

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | | | |
|--|--|--|--|---|--|--|---|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
Levienna E. Becker | | | | 2. DATE OF DEATH
MONTH DAY YEAR
May 10 1996 | | 3. TIME OF DEATH
9:10 P. M | | | | | |
| 4. SOCIAL SECURITY NUMBER
578-05-5771 | | 5. SEX
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
83 YRS. | | 7. DATE OF BIRTH
(Month, Day, Year)
JAN. Nov. 4, 1912 | | 8. BIRTHPLACE (State or Foreign Country)
Washington, D.C. | | | |
| 9a. FACILITY NAME (If not institution, give street and number)
Mariner Health Care Center | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
Laurel | | | 9c. COUNTY OF DEATH
Prince George's | | | | |
| 10a. STATE
Maryland | | 10b. COUNTY
Prince George's | | 10c. CITY, TOWN OR LOCATION
Upper Marlboro | | | 10d. INSIDE CITY LIMITS?
1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | |
| 10e. STREET AND NUMBER
6608 Hallam Drive | | | | 10f. ZIP CODE
20772 | | 10g. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | | | |
| 11. MARITAL STATUS
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify: White | | | | | |
| 15. DECEDENT'S EDUCATION
(Specify only highest grade completed)
Elementary/Secondary (0-12) 12
College (14 or 5+) _____ | | 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.)
Secretary | | 16b. KIND OF BUSINESS/INDUSTRY
Peoples Drug Store | | | | | | | |
| 17. FATHER'S NAME (First, Middle, Last)
Vernon Upthegrove | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Virginia Gunnell | | | | | | | |
| 19a. INFORMANT'S NAME (Type/Print)
Elizabeth R. Gray | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
6608 Hallam Dr. Upper Marlboro, Maryland 20772 | | | | | | | |
| 20a. METHOD OF DISPOSITION
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
Ft. Lincoln Cemetery 5/14/96 | | 20c. LOCATION — City or Town, State
Brentwood, Maryland | | | | | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
<i>George P. Kalas</i> | | | | 22. NAME AND ADDRESS OF FACILITY
George P. Kalas Funeral Home
6160 Oxon Hill Rd. Oxon Hill, Md. 20745 | | | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Pneumonia
DUE TO (OR AS A CONSEQUENCE OF):
b. DUE TO (OR AS A CONSEQUENCE OF):
c. DUE TO (OR AS A CONSEQUENCE OF):
d. DUE TO (OR AS A CONSEQUENCE OF):
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | | Approximate Interval Between Onset and Death
5 days | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | | 24a. WAS AN AUTOPSY PERFORMED?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA
OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | | | |
| 27. MANNER OF DEATH
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation
2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined
3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY
(Month, Day, Year) | | 28b. TIME OF INJURY
M | | 28c. INJURY AT WORK?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | | | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. CERTIFIER (Check only one)
1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
<i>Gregory A. Compton</i> | | | | 29c. LICENSE NUMBER
D 24942 | | 29d. DATE SIGNED (Month, Day, Year)
May 11, 1996 | | | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
Gregory A. Compton 8317 Cherry Lane, Laurel, Md. 20707 | | | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
MAY 14 1996 | | | | 32. REGISTRAR'S SIGNATURE
<i>John Andrew Carroll</i> | | | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

P.O. BOX 68760

DIVISION OF VITAL RECORDS

(10)

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 15703

Amended # 46.4 18. P.G.C. 5-6-96 CR Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Linda Brown

2. Date of Death
Month Day Year
04 28 1996

3. Time of Death
0127

Funeral
Director

4a. Facility Name (If not Institution, give street and number)

UNIVERSITY OF MARYLAND HOSPITAL

4b. City, Town, or Location of Death
BALTIMORE D.C.

4c. County of Death
BALTIMORE, M.D.

5. Social Security Number

218-80-0440

6. Sex
1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)
Yrs. 34

If Under 1 Year
Months Days

If Under 24 Hrs.
Hours Min.

8. Date of Birth
(Month, Day, Year)
MAY 25, 61

9. Birthplace (State or Foreign
Country)
WASH, D.C.

Usual Residence of Decedent

10a. State

MARYLAND BALTO

10b. County

10c. City, Town or Location

BALTIMORE, MARYLAND

10d. Inside City Limits
1 ☒ Yes 2 ☐ No

10e. Street and Number

2306 KENTVILLAGE LANDOVER MD.

10f. Zip Code

20785

10g. Citizen of What Country?

LANDOVER/USA

11. Marital Status

1 ☒ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.
Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,
Black, White, etc.

Specify: BLACK

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

12th GRADE

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

INVENTORY SERVICE

16b. Kind of Business/Industry

STORES AND WAREHOUSE
WASH. SERVICE

17. Father's Name (First, Middle, Last)

ARTHUR BROWN

18. Mother's Name (First, Middle, Maiden Surname)

EUNICE M STEADMON STEADMON

19a. Informant's Name/Relationship (Type, Print)

EUNICE M BROWN

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1501 OLIVE ST. S.E. DC.

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of
cemetery, crematory or other place)

HARMONY CEMETERY

Date

5-4-96

20c. Location - City or Town, State

LANDOVER P.G.C.

21. Signature of Funeral Service Licensee

Doyle D. Smith Jr.

22. Name and Address of Facility

874 MODERN FUNERAL 3821 14th ST. NW. DC.

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.

Immediate Cause (Final
disease or condition
resulting in death)

a. Pulmonary insufficiency
Due to (or as a consequence of):

3 days

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. Fibrotic lung disease
Due to (or as a consequence of):

1 years

c. Sarcoidosis
Due to (or as a consequence of):

6 years

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy
performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings
available prior to
completion of cause
of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical
examiner?
1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending Investigation
6 ☐ Could not be determined

28a. Date of Injury
(Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?
1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number,
City or Town, State)

29a. Certifier
(Check only
one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

S. Kupferschmid, M.D.

29c. License number

P09746

29d. Date signed (Month, Day, Year)

04/28/96

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

S Kupferschmid #22 SOUTH GREEN ST, BALTIMORE, MARYLAND

31. Date filed (Month, Day, Year)

MAY 06 1996

32. Registrar's Signature

Julia Anderson

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

5

1210 2001 85 40

2700 8
2700 1
2700 2

01/13/10

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

96 15704

Reg. No.

| | | | | | | | | |
|---|---|--|--|--|---|--------------------------------|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
HATTIE B BELL | | | | 2. Date of Death
Month Day Year
APRIL 27 1996 | | 3. Time of Death
5:07 AM | |
| | 4a. Facility Name (If not institution, give street and number)
SOUTHERN MARYLAND HOSPITAL | | | | 4b. City, Town, or Location of Death
CHINTON | | 4c. County of Death
PRINCE GEORGES | |
| Funeral
Director | 5. Social Security Number
231-01-6700 | | 6. Sex
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)
74 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth (Month, Day, Year)
MAY 19, 1921 | 9. Birthplace (State or Foreign Country)
Virginia |
| | Usual Residence of Decedent | | | | 10a. State
Maryland | | 10b. County
Prince Georges | |
| To Be Completed by Funeral Director | 10c. City, Town or Location
Temple Hills | | | | 10d. Inside City Limits
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 10e. Street and Number
2113 Iverson Street | |
| | 10f. Zip Code
20748 | | | | 10g. Citizen of What Country?
U.S.A | | 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | |
| To Be Completed by Physician/Medical Examiner | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: Black | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 10 Collegia (1-4or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Housewife | | 16b. Kind of Business/Industry
Home | |
| To Be Completed by Physician/Medical Examiner | 17. Father's Name (First, Middle, Last)
Calib Lee Morris | | | | 18. Mother's Name (First, Middle, Maiden Summa)
Ella Boase | | | |
| | 19a. Informant's Name/Relationship (Type, Print)
Lelia Bell-Mantley - Daughter | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
2113 Iverson St., Temple Hills Md. 20748 | | | |
| To Be Completed by Physician/Medical Examiner | 20a. Method of Disposition
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Carver Memorial Cems | | 20c. Location - City or Town, State
5-4-96 Suffolk, VA | |
| | 21. Signature of Funeral Service Licensee
Shelly Bell | | | | 22. Name and Address of Facility
Lewis Funeral Home
311 N. Patrick St., Alex. VA. 22314 | | | |
| To Be Completed by Physician/Medical Examiner | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. Respiratory failure. Bronchiolitis obliterans, bronchopneumonia
Due to (or as a consequence of):
b. HTN, Hypertrophic Cardiomyopathy
Due to (or as a consequence of):
c. Chronic renal failure, anemia.
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last | | | | | | | Approximate Interval Between Onset and Death |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |
| To Be Completed by Physician/Medical Examiner | 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |
| | 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one)
Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | |
| To Be Completed by Physician/Medical Examiner | 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicida 4 <input type="checkbox"/> Homicida
5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | |
| | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | 28d. Describe how injury occurred | | 28e. Location (Street and Number or Rural Route Number, City or Town, State) | |
| To Be Completed by Physician/Medical Examiner | 29a. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | 29b. Signature and title of certifier
M. Saeed Koo Laee, M.D. | | 29c. License number
D46260 | |
| | 29d. Date signed (Month, Day, Year)
APR 29, 1996 | | | | 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)
M. SAEED KOO LAEE, 6188 OXON HILL RD. OXON HILL, MD. | | | |
| To Be Completed by Physician/Medical Examiner | 31. Date filed (Month, Day, Year)
MAY 07 1996 | | | | 32. Registrar's Signature
John A. ... | | | |

96 15705

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|--|--|--|--|--|
| 1. DECEASED'S NAME (First, Middle, Last)
<i>Isabel Brock</i> | | | | 2. DATE OF DEATH
MONTH <i>4</i> DAY <i>30</i> YEAR <i>1996</i> | | 3. TIME OF DEATH
<i>12:50</i> M | |
| 4. SOCIAL SECURITY NUMBER
<i>578-28-4059</i> | | 5. SEX
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
<i>80</i> YRS. | | 7. DATE OF BIRTH (Month, Day, Year)
<i>Feb. 27, 1916</i> | |
| 8. BIRTHPLACE (State or Foreign Country)
<i>Purcellville, MD</i> | | | | 9a. FACILITY NAME (If not institution, give street and number)
<i>CARRIAGE HILL NURSING CENTER</i> | | 9b. CITY, TOWN OR LOCATION OF DEATH
<i>Silver Spring</i> | |
| 9c. COUNTY OF DEATH
<i>Montgomery</i> | | | | 10a. STATE
<i>District of Columbia</i> | | 10b. COUNTY
<i>Washington</i> | |
| 10c. CITY, TOWN OR LOCATION
<i>Washington</i> | | | | 10d. INSIDE CITY LIMITS?
1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 10e. STREET AND NUMBER
<i>2112 I Street, N. E. Apt. 10</i> | |
| 10f. ZIP CODE
<i>20002</i> | | | | 10g. CITIZEN OF WHAT COUNTRY?
<i>United States</i> | | 11. MARITAL STATUS
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | |
| 12. WAS DECEASED EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | | | 13. WAS DECEASED OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | | |
| 14. RACE — American Indian, Black, White, etc.
Specify:
<i>Black</i> | | | | 15. DECEASED'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12) <i>9</i> College (1-4 or 5+) <i>College (1-4 or 5+)</i> | | | |
| 16a. DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
<i>Hotel Maid</i> | | | | 16b. KIND OF BUSINESS/INDUSTRY
<i>Private</i> | | | |
| 17. FATHER'S NAME (First, Middle, Last)
<i>Lucian Thornton</i> | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
<i>Martha Anderson</i> | | | |
| 19a. INFORMANT'S NAME (Type/Print)
<i>McKinley Brock - Son</i> | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
<i>8500 16th Street, #320, Silver Spring, MD 20910</i> | | | |
| 20a. METHOD OF DISPOSITION
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
<i>Arlington National Cemetery 5/6/96 Arlington, VA</i> | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
<i>John T. Stewart III</i> | | | | 22. NAME AND ADDRESS OF FACILITY
<i>STEWART FUNERAL HOME, Inc.
4001 Benning Road, N.E., Washington, D.C.</i> | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Metastatic Lung Cancer</i>
DUE TO (OR AS A CONSEQUENCE OF):
a. <i>Metastatic Lung Cancer</i>
b. DUE TO (OR AS A CONSEQUENCE OF):
c. DUE TO (OR AS A CONSEQUENCE OF):
d. <i>7 then 1 mark</i> | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA
OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | |
| 27. MANNER OF DEATH
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation
2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined
3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | | | 28a. DATE OF INJURY (Month, Day, Year)
<i>Feb. 27, 1916</i> | | | |
| 28b. TIME OF INJURY
<i>M</i> | | | | 28c. INJURY AT WORK?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | 29a. CERTIFIER (Check only one)
1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
<i>Carol Alonzo M.D.</i> | | | | 29c. LICENSE NUMBER
<i>P43996</i> | | | |
| 29d. DATE SIGNED (Month, Day, Year)
<i>April 29, 1996</i> | | | | 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
<i>MOHAMMAD A. KHALID 8830 - Cameron Street Silver Spring MD</i> | | | |
| 31. DATE FILED (Month, Day, Year)
<i>MAY 07 1996</i> | | | | 32. REGISTRAR'S SIGNATURE
<i>Julia Anderson-Rodell</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

96 15706

Reg. No.

| | | | | | | | | | |
|---|--|---|---|--|--|---|--|---|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
WILLIAM J. BALL, JR. | | | | 2. Date of Death
Month Day Year
APRIL 24, 1996 | | 3. Time of Death
1750PM | | |
| | 4a. Facility Name (If not institution, give street and number)
5102 INDIAN HEAD HIGHWAY-PARKING LOT | | | | 4b. City, Town, or Location of Death
FOREST HEIGHTS | | 4c. County of Death
PRINCE GEORGES | | |
| Funeral
Director | 5. Social Security Number
579-76-9779 | | 6. Sex
1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 7. Age (In yrs. last birthday)
37 Yrs. | | 8. Date of Birth (Month, Day, Year)
JULY 16, 1958 | | |
| | 9. Birthplace (State or Foreign Country)
WASH., D.C. | | 10a. State
NA | | 10b. County
NA | | 10c. City, Town or Location
WASHINGTON, D.C. | | |
| Usual Residence of Decedent | | | | | | | | | |
| 10e. Street and Number
1011 7th Street, S.E. #305 | | | 10f. Zip Code
20003 | | | 10g. Citizen of What Country?
United States | | | |
| 11. Marital Status
1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: BLACK | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (1-4or 5+) 12 | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
MOVER/NURSE | | | 16b. Kind of Business/Industry
PRIVATE | | | |
| 17. Father's Name (First, Middle, Last)
WILLIAM J. BALL, SR. | | | | 18. Mother's Name (First, Middle, Maiden Surname)
DELORES THOMAS | | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
DELORES T. JOHNSON / MOTHER | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1011 7th St., S.E. #305, Washington, D.C. 20003 | | | | | |
| 20a. Method of Disposition
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
HARMONY MEMORIAL PARK | | 20c. Location - City or Town, State
5/3/96 LANDOVER, MARYLAND | | 20d. Date | | |
| 21. Signature of Funeral Service Licensee
<i>Ally S. Pope Jr.</i> M859 | | | | 22. Name and Address of Facility
ALEXANDER S. POPE FUNERAL HOMES
5538 MARLBORO PIKE, FORESTVILLE, MD. 20747 | | | | | |
| 23a. Part I. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
a. <i>Gunshot Wounds (2) of Head and Neck</i>
Due to (or as a consequence of):
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of):
Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last | | | | | | | | | |
| 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown | | | | | | | | | |
| 24a. Was an autopsy performed?
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death?
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | | | | | |
| 25. Was case referred to medical examiner?
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | 26. Place of Death (Check only one)
Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) AT SCENE | | | | | |
| 27. Manner of Death
1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input checked="" type="checkbox"/> Homicide
5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year)
4/24/96 | | 28b. Time of Injury
1530 HR | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred
Subject shot | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
vehicle near liquor store | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State)
5102 Indian Head Highway, South Forest Heights, Maryland | | | | | |
| 29a. Certifier (Check only one)
1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | 29b. Signature and title of certifier
<i>Theodore M. King</i> | | | | | |
| 29c. License number
O.C.M.E. | | | | 29d. Date signed (Month, Day, Year)
APRIL 25, 1996 | | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
THEODORE M. King 111 Penn Street, Baltimore, Maryland 21201 | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
MAY 07 1996 | | | | 32. Registrar's Signature
<i>John H. ...</i> | | | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

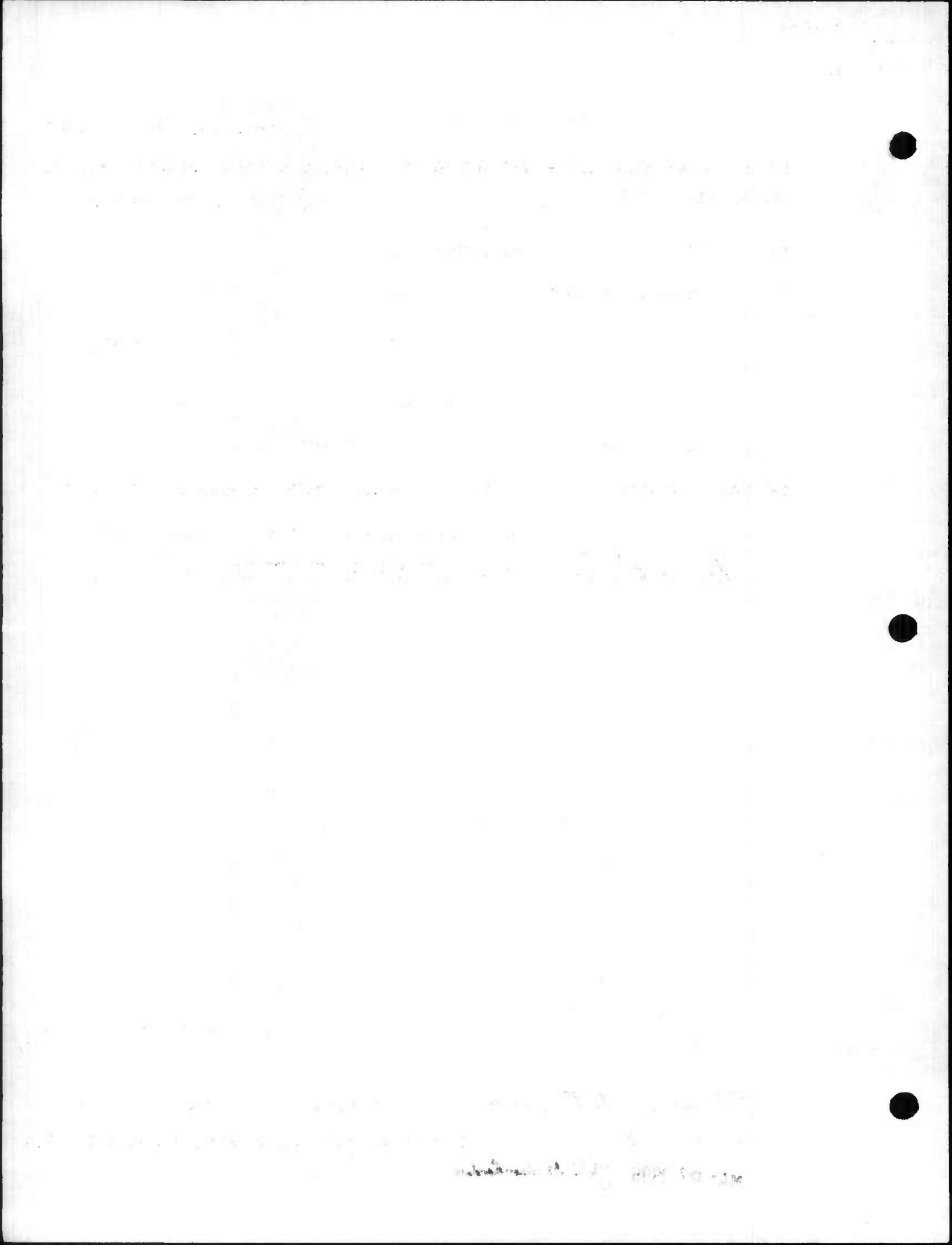
Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 15707

Certificate of Death

Reg. No.

| | | | | | | | | | | | | | | |
|---|--|--|---|---|--|---------------------------------|--|--|--|-----------------------------------|--|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Kirk Walter Bivens | | | | 2. Date of Death
Month 11 , Day 1996 Year | | | | 3. Time of Death
428 A | | | | | |
| | 4a. Facility Name (If not institution, give street and number)
1870 Emmanuel Church Road | | | | 4b. City, Town, or Location of Death
Huntingtown | | | | 4c. County of Death
Calvert | | | | | |
| Funeral
Director | 5. Social Security Number
213 34 9105 | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday)
60 Yrs. | | If Under 1 Year
Months Days | | If Under 24 Hrs.
Hours Min. | | 8. Date of Birth (Month, Day, Year)
February 7 1936 | | 9. Birthplace (State or Foreign Country)
Washington DC | |
| | Usual Residence of Decedent | | | | | | | | | | | | | |
| To Be Completed by Funeral Director | 10a. State
Maryland | | 10b. County
Calvert | | 10c. City, Town or Location
Huntingtown | | | | | | 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | |
| | 10e. Street and Number
1870 Emmanuel Church Road | | | | 10f. Zip Code
20639 | | | | 10g. Citizen of What Country?
United States | | | | | |
| | 11. Marital Status
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
If Yes, Give Year or Dates: - 61 | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | | 14. Race - American Indian, Black, White, etc.
Specify: white | | | | | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (1-4or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
telecommunications Operator State Dept. | | | | 16b. Kind of Business/Industry | | | | | |
| | 17. Father's Name (First, Middle, Last)
William Walter Bivens | | | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Margaret Ashley Robinson | | | | | | | |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print)
Edward Bivens | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1870 Emmanuel Church Huntingtown Maryland 20639 | | | | | | | | | |
| | 20a. Method of Disposition
<input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Metropolitan Crematory | | | | Date
May 11, 1996 | | 20c. Location - City or Town, State
Alexandria Virginia | | | |
| | 21. Signature of Funeral Service Licensee
B. B. Bausch | | | | 22. Name and Address of Facility
Rausch Funeral Home 20676
4405 Broomes Island Road Port Republic Maryland | | | | | | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Refractory Congestive Heart Failure 2-3
Due to (or as a consequence of):
b. Ischemic Cardiomyopathy
Due to (or as a consequence of):
c. Coronary artery Disease
Due to (or as a consequence of):
d.

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | | | | | | | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Chronic Myelogenous Leukemia
Insulin Dependent Diabetes Mellitus | | | | | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation
<input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined
<input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input type="checkbox"/> No | | 28d. Describe how injury occurred | | | | |
| | | | | 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | | | | | | | |
| 29b. Signature and title of certifier
Dr. Atmunda M. Allen | | | | 29c. License number
D 19427 | | | | 29d. Date signed (Month, Day, Year)
5/11/96 | | | | | | |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)
Anwar T. Munshi, M.D., 110 Hospital Rd., Prince Frederick, MD 20678 | | | | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
MAY 13 1996 | | | | 32. Registrar's Signature
William Randall | | | | | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

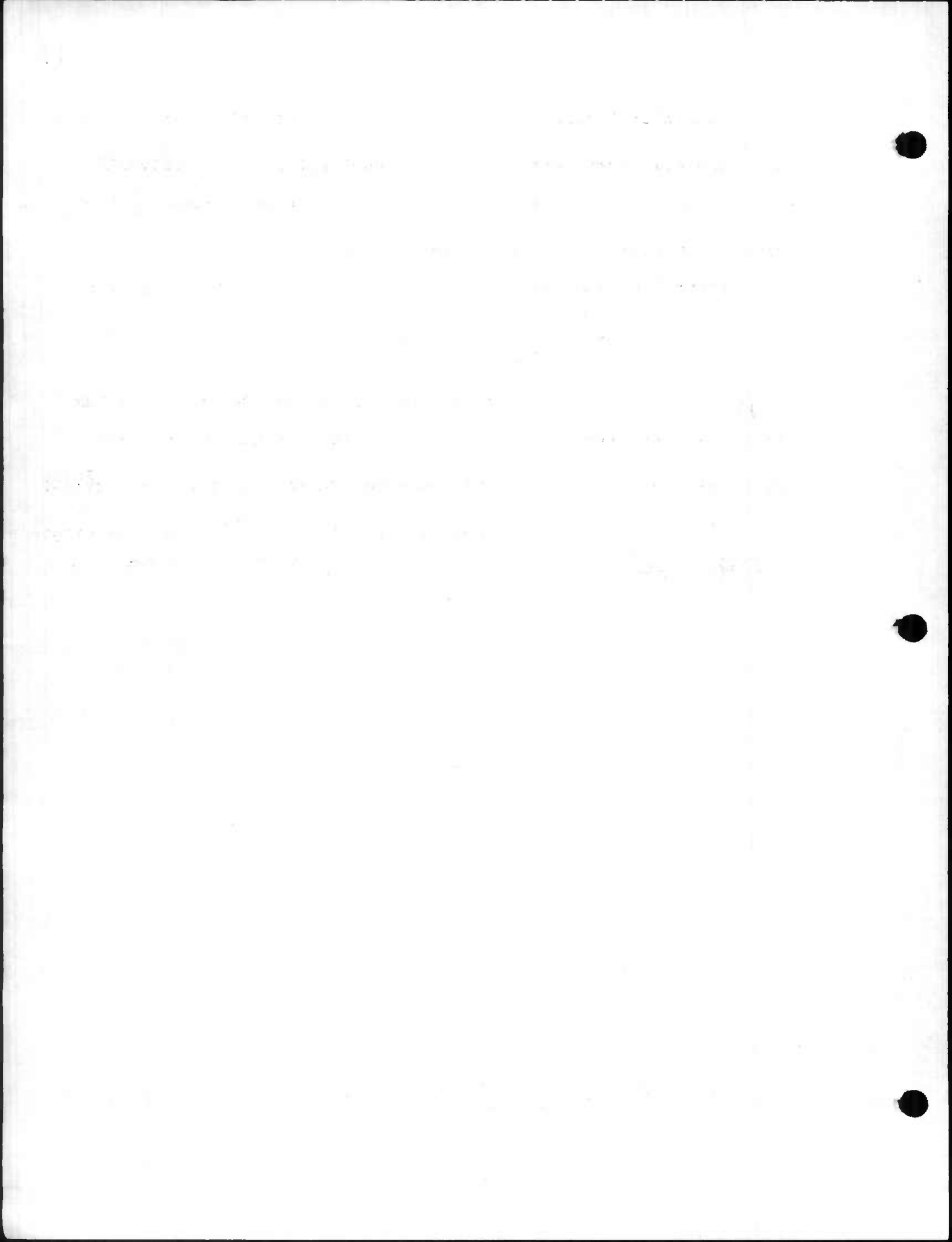
Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 15708

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permt. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician / Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician / Medical Examiner

Funeral Director

| | | | | | | |
|---|--|--|---|--|---|--|
| 1. Decedent's Name (First, Middle, Last)
BRENDA LYNN BRYANT | | | 2. Date of Death
Month MAY Day 3 , Year 1996 | | 3. Time of Death
0650 AM | |
| 4a. Facility Name (If not institution, give street and number)
11000 BLK. LIVINGSTON ROAD | | | 4b. City, Town, or Location of Death
FORT WASHINGTON | | 4c. County of Death
PRINCE GEORGES | |
| 5. Social Security Number
217-82-5013 | | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)
36 Yrs. | | 8. Date of Birth (Month, Day, Year)
JAN. 12, 1960 | |
| 9. Birthplace (State or Foreign Country)
WASH. DC | | | | | | |
| Usual Residence of Decedent | | | | | | |
| 10a. State
MD | | 10b. County
PRINCE GEORGES | | 10c. City, Town or Location
SUITLAND | | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |
| 10e. Street and Number
4415 RENA ROAD, #203 | | | 10f. Zip Code
20746 | | 10g. Citizen of What Country?
U.S.A. | |
| 11. Marital Status
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: BLACK |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 Collage (1-4 or 5+) | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
ADMINISTRATIVE ASSISTANT | | 16b. Kind of Business/Industry
P.G. COUNTY GOV'T | |
| 17. Father's Name (First, Middle, Last)
VINCENT L. DODSON | | | | 18. Mother's Name (First, Middle, Maiden Surname)
YVONNE LEE | | |
| 19a. Informant's Name/Relationship (Type, Print)
MICHAEL BRYANT-HUSBAND | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
4415 RENA ROAD, #203 SUITLAND, MD 20746 | | | |
| 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
MARYLAND NATIONAL CEM. | | 20c. Location - City or Town, State
LAUREL, MARYLAND | | 20d. Date
5-9-96 |
| 21. Signature of Funeral Service Licensed
<i>B.C. Taylor</i> | | | 22. Name and Address of Facility
TAYLOR'S FUNERAL HOME
1722 NORTH CAPITOL ST., NW WASH. DC 20001 | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. <i>Multiple Injuries</i>
Dua to (or as a consequence of):

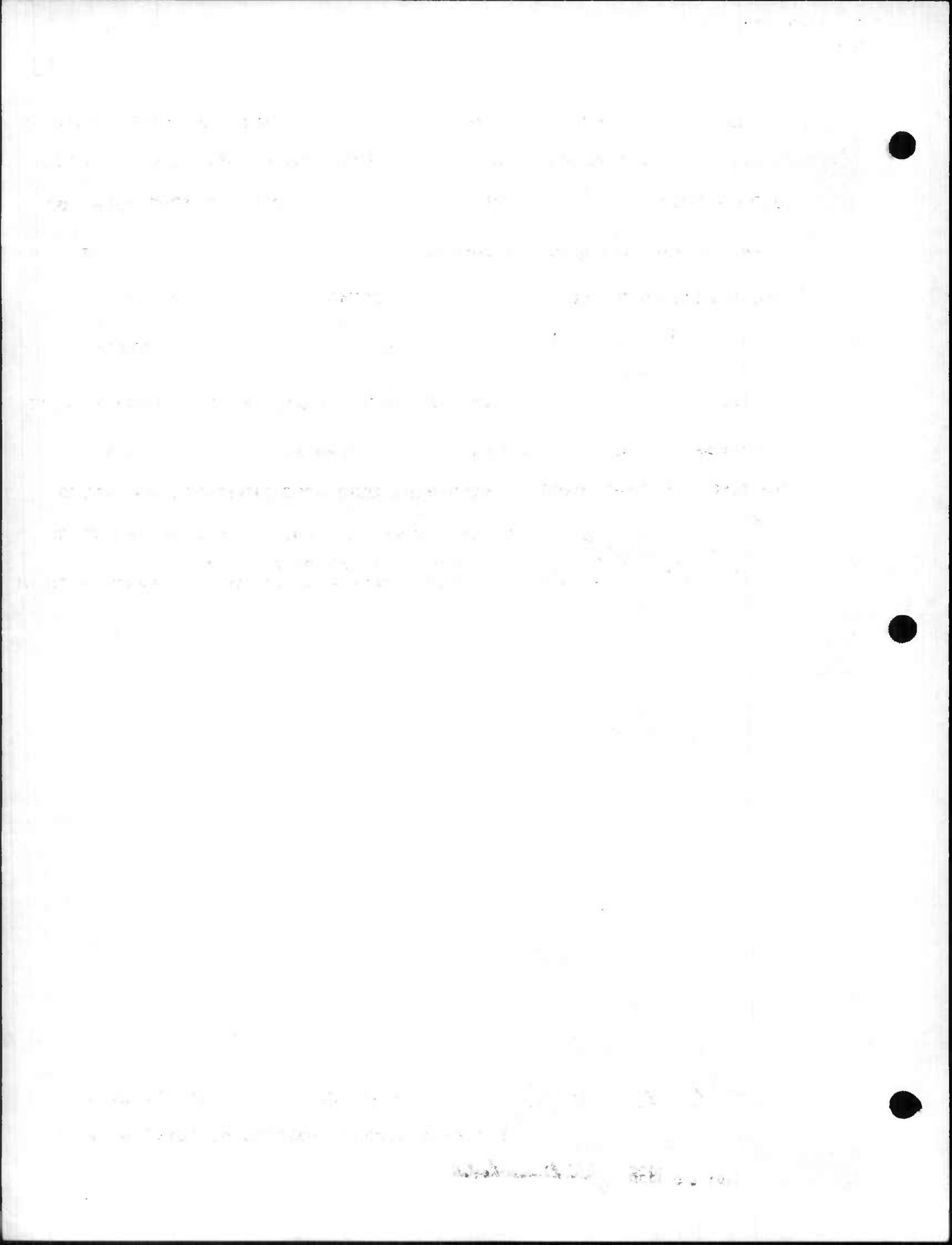
b.
Dua to (or as a consequence of):

c.
Dua to (or as a consequence of):

d.
Dua to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. | | | | | | |
| 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | | | | | |
| 24a. Was an autopsy performed?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | |
| 25. Was case referred to medical examiner?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) ROADWAY | | | | |
| 27. Manner of Death
<input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year)
5/3/96 | | 28b. Time of Injury
5:55 AM | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
roadway | | 28d. Describe how injury occurred
Subject pedestrian struck by | | | | |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)
Livingstone Road Prince Georges | | 28e. Location (Street and Number or Rural Route Number, City or Town, State)
Livingstone Road Prince Georges | | | | |
| 29a. Certifier (Check only one)
<input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.
<input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | |
| 29b. Signature and title of certifier
<i>Theodore M. King</i> | | | 29c. License number
O.C.M.E | | 29d. Date signed (Month, Day, Year)
MAY 3, 1996 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
THEODORE M. KING 111 Penn Street, Baltimore, Maryland 21201 | | | | | | |
| 31. Date filed (Month, Day, Year)
MAY 08 1996 | | | | | | |
| 32. Registrar's Signature
<i>John H. ...</i> | | | | | | |

State Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 15709

Certificate of Death

Reg. No.

| | | | | | | | | |
|---|---|---|--|--|--|--|---|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
FRANK BETHEA | | | | 2. Date of Death
Month MAY Day 6 Year 1996 | | 3. Time of Death
7:05AM | |
| | 4a. Facility Name (If not institution, give street and number)
HOWARD COUNTY GENERAL HOSPITAL | | | | 4b. City, Town, or Location of Death
COLUMBIA | | 4c. County of Death
HOWARD | |
| Funeral
Director | 5. Social Security Number
578-03-3529 | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)
68 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth (Month, Day, Year)
Dec. 17, 1909 | 9. Birthplace (State or Foreign Country)
Dillon S.C. |
| | Usual Residence of Decedent | | | | | | | |
| 10a. State
Maryland | | 10b. County
Howard | | 10c. City, Town or Location
Columbia | | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | |
| 10e. Street and Number
6820 Sewells Orchard Drive | | | | 10f. Zip Code
21045 | | 10g. Citizen of What Country?
United States | | |
| 11. Marital Status
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify:
African American | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 2 College (1-4 or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Retired Federal Employee | | 16b. Kind of Business/Industry
Government - GSA | | |
| 17. Father's Name (First, Middle, Last)
Dennis Bethea | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Mary Ann McRay | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
John W. Kinney, Jr. | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
6820 Sewells Orchard Drive, Columbia, MD 21045 | | | | |
| 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Maryland National Memorial Park | | Date
5/10/96 | | 20c. Location - City or Town, State
Laurel, Maryland | | |
| 21. Signature of Funeral Service Licensee
John T. Stewart III | | | | 22. Name and Address of Facility
STEWART FUNERAL HOME, Inc.
4001 Benning Road, N.E., Washington, D. C. | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. PNEUMONIA
Due to (or as consequence of):
b. DEMENTIA
Due to (or as consequence of):
c.
Due to (or as consequence of):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | | |
| Approximate Interval Between Onset and Death
5 DAYS

YEARS | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
DEHYDRATION, HYPERCALCEMIA, RENAL FAILURE, HYPERTENSION, FECAL IMPACTION, CORONARY ARTERY DISEASE, CHRONIC OBSTRUCTIVE LUNG DISEASE | | | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | |
| | | | | | | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28. Place of Death (Check only one)
Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| 28d. Describe how injury occurred | | | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | |
| 29b. Signature and title of certifier
John T. Stewart III | | | | 29c. License number
D38296 | | 29d. Date signed (Month, Day, Year)
MAY 6, 1996 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
JOSEPH GIBBONS, MD 9501 OLD ANNAPOLIS RD, ELLICOTT CITY, MD 21042 | | | | | | | | |
| 31. Date filed (Month, Day, Year)
MAY 9 1996 | | | | 32. Registrar's Signature
John T. Stewart III | | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

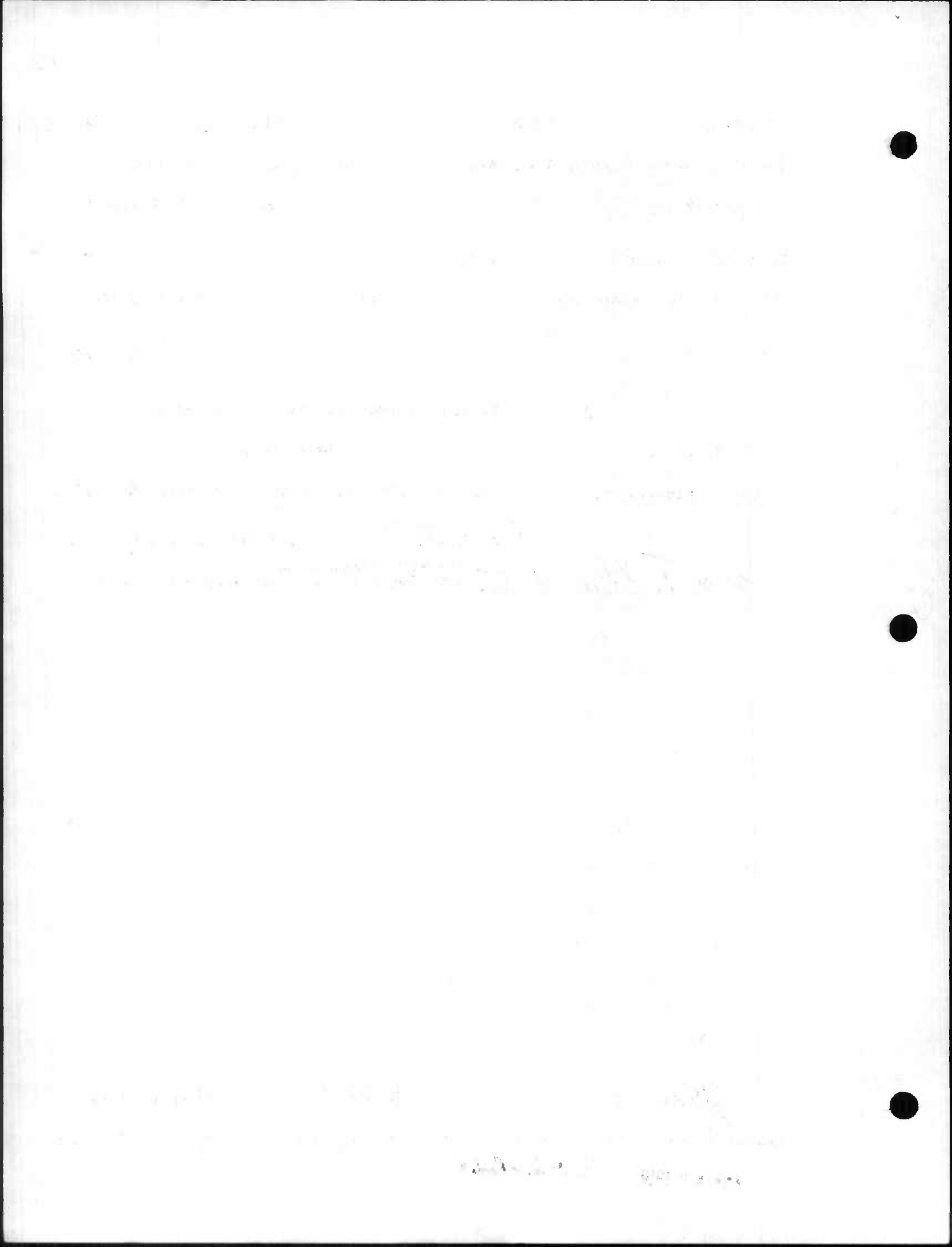
Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

State
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 15710

ITEMS: 27, 28a, b, c, d, e, f per MEO G-736 6/26/96

Reg. No.

| Physician / Medical Examiner | | Funeral Director | | To Be Completed by Funeral Director | |
|--|--|---|--|--|--|
| 1. Decedent's Name (First, Middle, Last)
KATHRYN ANN BURNS | | 2. Date of Death
Month Day Year
MAY 12, 1996 | | 3. Time of Death
2054PM | |
| 4a. Facility Name (If not institution, give street and number)
SUBURBAN HOSPITAL E.R. | | 4b. City, Town, or Location of Death
BETHESDA | | 4c. County of Death
MONTGOMERY | |
| 5. Social Security Number
215-64-2344 | | 6. Sex
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday)
40 Yrs. | |
| 8. Date of Birth (Month, Day, Year)
Apr. 11, 1956 | | 9. Birthplace (State or Foreign Country)
Maryland | | 10. Inside City Limits
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| 10a. State
Maryland | | 10b. County
Montgomery | | 10c. City, Town or Location
Silver Spring | |
| 10d. Street and Number
13920 Castle Blvd., Apt. 11B | | 10e. Zip Code
20904 | | 10f. Citizen of What Country?
U.S.A. | |
| 11. Marital Status
1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | |
| 14. Race - American Indian, Black, White, etc.
Specify: White | | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (1-4 or 5+) College (1-4 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
landscape technician | |
| 16b. Kind of Business/Industry
nursery | | 17. Father's Name (First, Middle, Last)
Gregg C. Burns | | 18. Mother's Name (First, Middle, Maiden Surname)
Marie LaForge | |
| 19a. Informant's Name/Relationship (Type, Print)
Elizabeth Gibson/ sister | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
806B Harwood Ct. Mt. Laurel, NJ 08054 | | 20a. Method of Disposition
1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | |
| 20b. Place of Disposition (Name of cemetery, crematory or other place)
Carroll Cremation, Inc. | | 20c. Date
5/15/96 | | 20d. Location - City or Town, State
Hampstead, MD | |
| 21. Signature of Funeral Service Licensee
<i>Catharine D. Hartzler</i> | | 22. Name and Address of Facility
Hartzler Funeral Home
New Windsor, MD | | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. Gunshot Wound of Chest
Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | |
| 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | 24a. Was an autopsy performed?
<input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death?
<input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| 25. Was case referred to medical examiner?
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | 27. Manner of Death
1 <input type="checkbox"/> Natural 2 <input checked="" type="checkbox"/> Pending Investigation 3 <input type="checkbox"/> Accidental 4 <input type="checkbox"/> Suicidal 5 <input type="checkbox"/> Homicidal 6 <input type="checkbox"/> Could not be determined | |
| 28a. Date of Injury (Month, Day, Year)
5/11/96 | | 28b. Time of Injury
7:30 P M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | |
| 28d. Describe how injury occurred
SUBJECT WAS SHOT | | 28e. Location (Street and Number or Rural Route Number, City or Town, State)
13920 CASTLE BLVD., APT. 11B | | 28f. Location (Street and Number or Rural Route Number, City or Town, State)
SILVER SPRING, MD. | |
| 29a. Certifier (Check only one)
1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier
<i>Dennis J. Chute MD</i> | | 29c. License number
O.C.M.E. | |
| 29d. Date signed (Month, Day, Year)
MAY 13, 1996 | | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Dennis J. Chute MD | | 31. Date filed (Month, Day, Year)
MAY 16 1996 | |
| 32. Registrar's Signature
<i>John Davidson Randall</i> | | 33. State Registrar
MAY 16 1996 | | 34. State Registrar
MAY 16 1996 | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Faxed to 749-3278
on 5/3/96 1240 AR

Robert Blanchard
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene
Certificate of Death

96 15711

Reg. No.

Physician
/Medical
Examiner

Federal
Director

| | | | | | | | | | |
|---|--|---|---|--|---|--|--|---|--|
| 1. Decedent's Name (First, Middle, Last)
ROBERT ARTHUR BLANCHARD | | | 2. Date of Death
Month Day Year
May 1, 1996 | | | 3. Time of Death
2235 | | | |
| 4a. Facility Name (If not institution, give street and number)
ATLANTIC GENERAL HOSPITAL | | | 4b. City, Town, or Location of Death
BERLIN | | | 4c. County of Death
WORCESTER | | | |
| 5. Social Security Number
161-20-5726 | | 6. Sex
1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | 7. Age (In yrs. last birthday)
69 Yrs. | | 8. Date of Birth (Month, Day, Year)
August 9, 1926 | | 9. Birthplace (State or Foreign Country)
Paris, France | | |
| Usual Residence of Decedent | | | | | | | | | |
| 10a. State
Maryland | | 10b. County
Wicomico | | 10c. City, Town or Location
Fruitland | | | 10d. Inside City Limits
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | |
| 10e. Street and Number
4130 Disharoon Rd. | | | 10f. Zip Code
21826 | | | 10g. Citizen of What Country?
USA | | | |
| 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No
If Yes, Give Year or Dates: WW II | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc.
Specify: White | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 Collage (1-4 or 5+) 0 | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Credit manager | | | 16b. Kind of Business/Industry
Credit corp. | | | |
| 17. Father's Name (First, Middle, Last)
Jean Blanchard | | | 18. Mother's Name (First, Middle, Maiden Surname)
Marie Angel Millescamp | | | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
Hazel R. Blanchard | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
6301 George Island Landing Rd., Stockton, MD 21864 | | | | | | |
| 20a. Method of Disposition
1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Salisbury Crematory | | Date
5/4/96 | | 20c. Location - City or Town, State
Salisbury, MD | | |
| 21. Signature of Funeral Service Licensee
<i>David H. Thompson</i> | | | 22. Name and Address of Facility
Holloway Funeral Home
501 Snow Hill Rd., Salisbury, MD 21804 | | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. Lung Cancer
Due to (or as a consequence of):
b. Malignant Pleural effusion
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | Approximate Interval Between Onset and Death
Unknown | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown | | | |
| | | | | | | 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | |
| | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | |
| 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | 26. Place of Death (Check only one)
Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide
5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | |
| | | | 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | 28d. Describe how Injury occurred | | | |
| 29a. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | 29b. Signature and title of certifier
<i>Scott Sweetney</i> | | | 29c. License number
H43617 | | 29d. Date signed (Month, Day, Year)
5/2/96 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Scott Sweetney 11220 Beachmont Rd Berlin MD 21011 | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
MAY 10 1996 | | | 32. Registrar's Signature
<i>John Davidson-Rodell</i> | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

State
Registrar

1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH REG. NO.

REG NO

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| | | | | | | | |
|---|--|--|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
Mary Ellen Smothers Bantum | | | | 2. DATE OF DEATH
MONTH DAY YEAR
May 11, 1996 | | 3. TIME OF DEATH
8:00 AM | |
| 4. SOCIAL SECURITY NUMBER
213-22-5505 | | 5. SEX
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | 6. AGE (In yrs. last birthday)
81 YRS. | 7. DATE OF BIRTH (Month, Day, Year)
Feb. 5, 1915 | | 8. BIRTHPLACE (State or Foreign Country)
Maryland | |
| 9a. FACILITY NAME (If not institution, give street and number)
201 Federal St. Apt. 57 | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
Easton | | 9c. COUNTY OF DEATH
Talbot | |
| 10a. STATE
Maryland | | | | 10b. COUNTY
Talbot | | 10c. CITY, TOWN OR LOCATION
Easton | |
| 10d. INSIDE CITY LIMITS?
<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | | | 10e. STREET AND NUMBER
201 Federal St. Apt. 57 | | 10f. ZIP CODE
21601 | |
| 11. MARITAL STATUS
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify:
Black | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12) 7 College (1-4 or 5+) | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
Domestic | | 16b. KIND OF BUSINESS/INDUSTRY
Private Family | |
| 17. FATHER'S NAME (First, Middle, Last)
John Wesley Smothers | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Mary McKinney | | | |
| 19a. INFORMANT'S NAME (Type/Print)
Charles Wilson Smothers | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
26643 Tunis Mills Rd. Easton, Maryland 21601 | | | |
| 20a. METHOD OF DISPOSITION
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
Hammon Town Cemetery 5/8 Easton, Maryland | | 20c. LOCATION — City or Town, State
21601 | | 20d. DATE
21613 | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
Janelle C. Henry | | | | 22. NAME AND ADDRESS OF FACILITY
HENRY FUNERAL HOME
510- Washington St. Cambridge, MD. 21613 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
IMMEDIATE CAUSE (Final disease or condition resulting in death) → myocardial infarction (MI)
Approximate interval Between Onset and Death: 14 months
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST {
hypertension
DUE TO (OR AS A CONSEQUENCE OF):
chronic bronchitis
DUE TO (OR AS A CONSEQUENCE OF):
20 years | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
chronic bronchitis | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | | | | |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
<input type="checkbox"/> YES <input type="checkbox"/> NO | | | | | | | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DQA
OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | |
| 27. MANNER OF DEATH
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation
<input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined
<input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M | |
| 28c. INJURY AT WORK
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. CERTIFIER (Check only one)
<input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
J. Corwin M.D. | | | | 29c. LICENSE NUMBER
033768 | | 29d. DATE SIGNED (Month, Day, Year)
May 16, 1996 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
J. Corwin M.D. P.O. Box 660 Denton MD 21629 | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
MAY 17 1996 | | | | 32. REGISTRAR'S SIGNATURE
John Davidson Randall | | | |

• Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

96 15713

Reg. No.

Amended # 18, PGC 5-10-96 cr

Physician
/Medical
Examiner

Walter Cummings

2. Date of Death
Month Day Year
05 03 96
3. Time of Death
5:15 PM

4a. Facility Name (If not institution, give street and number)

4107 Bishop Mill Drive

4b. City, Town, or Location of Death

Upper Marlboro

4c. County of Death

Prince George's

Funeral
Director

5. Social Security Number

577-01-9857

6. Sex
☒ M ☐ F

7. Age (In yrs. last birthday)

79 Yrs.

8. Data of Birth
(Month, Day, Year)

09-23-16

9. Birthplace (State or Foreign Country)

Lynchburg, VA

Usual Residence of Decedent

10a. State

Maryland

10b. County

Prince George's

10c. City, Town or Location

Upper Marlboro

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

4107 Bishop Mill Drive

10f. Zip Code

20772

10g. Citizen of What Country?

USA

11. Marital Status

☐ Never Married ☒ Married

☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

☒ Yes ☐ No Retired

If Yes, Give Year or Dates: 1969

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4or 5+)

12th

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Warehouseman

16b. Kind of Business/Industry

Government

17. Father's Name (First, Middle, Last)

William McKinley Cummings

18. Mother's Name (First, Middle, Maiden Surname)

Mae Ethel Elliott Christian

19a. Informant's Name/Relationship (Type, Print)

Ethel Cummings/Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4107 Bishop Mill Drive, Upper Marlboro, MD 20772

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State

4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Arlington National Cem. 5/15/96

Date

20c. Location - City or Town, State

Arlington, Virginia

21. Signature of Funeral Service Licensee

Kimberly C. Busch-Tonic

22. Name and Address of Facility

J. B. Jenkins Funeral Home
7474 Landover Road, Landover, MD 20785

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. NON-SMALL CELL LUNG CANCER

Due to (or as a consequence of):

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

2 MONTHS

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

CHRONIC RENAL INSUFFICIENCY

HYPERTENSION

23b. Did tobacco use contribute to the cause of death?

☒ Yes ☐ No ☐ Probably ☐ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☐ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

Hospital:

☐ Inpatient ☐ ER/Outpatient ☐ DOA

26. Place of Death (Check only one)

Other: ☐ Nursing Home ☒ Residence ☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending Investigation
☐ Accident ☐ Could not be determined
☐ Suicide ☐ Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

☐ Yes ☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Johnny T. Lu, M.D.

29c. License number

MI - 4301406 313

29d. Date signed (Month, Day, Year)

05-09-96

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JOHNNY T. LU DEPT. OF INTERNAL MEDICINE, MALCOLM GRON MED CTR, ANDREWS AFB 20762

31. Date filed (Month, Day, Year)

MAY 10 1996

32. Registrar's Signature

John Phelan-Randall

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

J.P.G. ITEMS: 23 PART I, II, 27, State of Maryland / Department of Health and Mental Hygiene 96 15714
28a-f, PER MEO FILM G-735 5/31/96 t.t Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)
Elsie L. Cheek

2. Date of Death
Month May Day 07 Year 1996
3. Time of Death
1807

Funeral
Director

4a. Facility Name (If not Institution, give street and number)

4b. City, Town, or Location of Death

4c. County of Death

Anne Arundel General Hospital E.R. Annapolis Anne Arundel

5. Social Security Number
241-70-7117

6. Sex
1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)
52 Yrs.

8. Date of Birth (Month, Day, Year)
August 1, 1943

9. Birthplace (State or Foreign Country)
North Carolina

Usual Residence of Decedent

10a. State
Maryland

10b. County
Prince George's

10c. City, Town or Location

Landover

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

841 Nalley Road

10f. Zip Code

20785

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.
Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
12th

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Nursing Assistant

16b. Kind of Business/Industry

Government

17. Father's Name (First, Middle, Last)

John Robert Harris

18. Mother's Name (First, Middle, Maiden Surname)

Lucy M. Gill

19a. Informant's Name/Relationship (Type, Print)

Gary Stephens Cheek

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

841 Nalley Road, Landover, MD 20785

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Harmony Memorial Park

Date

5/13/96

20c. Location - City or Town, State

Landover, MD

21. Signature of Funeral Service Licensor

J. B. Jenkins

22. Name and Address of Facility

J. B. Jenkins Funeral Home
7474 Landover Road, Landover, MD 20785

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. ASPIRATION OF FOOD

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

SCHIZOAFFECTIVE DISORDER

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☒ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?
1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one)
Hospital: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA

Other: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 5 ☐ Pending investigation
2 ☒ Accident 6 ☐ Could not be determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day, Year)
FOUND 5-7-96

28b. Time of Injury
5:05 P M

28c. Injury at Work?
1 ☐ Yes 2 ☒ No

28d. Describe how Injury occurred

SUBJECT ASPIRATED FOOD

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

FOUND: BATHROOM

28f. Location (Street and Number or Rural Route Number, City or Town, State)
CROWNSVILLE HOSPITAL CENTER, CROWNSVILLE, ANNE ARUNDEL CO. MD

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

J. B. Jenkins
JMDIXON

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

May 09 1996

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

111 Penn Street, Baltimore, Maryland 21201

31. Date filed (Month, Day, Year)

MAY 10 1996

32. Registrar's Signature

John M. Dixon

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 15715

Certificate of Death

Reg. No.

| | | | | | | | | | | | | |
|---|---|---|---|-------------------------------|---|--|---|-----------------------------------|--|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
TERRY BLAINE COLLINS | | | | 2. Date of Death
Month Day Year
May 3, 1996 | | | | 3. Time of Death
12:55 pm | | | |
| | 4a. Facility Name (If not Institution, give street and number)
8559 Wheatfield Way | | | | 4b. City, Town, or Location of Death
Ellicott City | | | | 4c. County of Death
Howard | | | |
| Funeral
Director | 5. Social Security Number
578-42-9411 | | 6. Sex
1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 7. Age (In yrs. last birthday)
63 Yrs. | | 8. Date of Birth (Month, Day, Year)
Dec. 30, 1932 | | 9. Birthplace (State or Foreign Country)
Maryland | | | |
| | Usual Residence of Decedent | | | | | | | | | | | |
| To Be Completed by Funeral Director | 10a. State
MD | | 10b. County
Howard | | 10c. City, Town or Location
Ellicott City | | | | 10d. Inside City Limits
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | |
| | 10e. Street and Number
8559 Wheatfield Way | | | | 10f. Zip Code
21043 | | | | 10g. Citizen of What Country?
White | | | |
| | 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | | 14. Race - American Indian, Black, White, etc.
Specify: White | | | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) Collage (1-4or 5+)
1 | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Civil Engineer | | | | 16b. Kind of Business/Industry
District Government | | | |
| | 17. Father's Name (First, Middle, Last)
Leonard Collins | | | | 18. Mother's Name (First, Middle, Maiden Summa)
Katherine A. Lathroum | | | | | | | |
| | 19a. Informant's Name/Relationship (Type, Print)
Sarah D. Collins - Spouse | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
8559 Wheatfield Way, Ellicott City, Maryland 21043 | | | | | | | |
| | 20a. Method of Disposition
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
MD Veteran's Cemetery | | 20c. Date
05/07/96 | | 20d. Location - City or Town, State
Cheltenham, Maryland | | | | | |
| | 21. Signature of Funeral Service Licensee
<i>W.B. Garcia</i> | | | | 22. Name and Address of Facility
Francis Gasch's Sons Funeral Home, P.A.
4739 Baltimore Avenue, Hyattsville, MD 20781 | | | | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. <i>NON SMALL CELL LUNG CANCER</i>
Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death
<i>YEARS</i> | | | | | | | | | | | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | | | | |
| 23b. Did tobacco use contribute to the cause of death?
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | | | | | | | | | | |
| 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | | | | | | | | |
| 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | | | | | | |
| 26. Place of Death (Check only one)
Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | | | | | | |
| 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide
5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | | | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier
<i>Michael Hawkins</i> | | 29c. License number
D41266 | | 29d. Date signed (Month, Day, Year)
5/6/96 | | | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Michael Hawkins, M.D. 3800 Reservoir Road NW, Washington, DC 20007 | | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
MAY 08 1996 | | | | | | | | | | | | |
| 32. Registrar's Signature
<i>John Anderson-Randall</i> | | | | | | | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

1. The first part of the paper is devoted to a discussion of the general principles of the theory of the structure of the atom.

2. In the second part, we shall consider the question of the influence of the external magnetic field on the structure of the atom.

3. The third part of the paper is devoted to a discussion of the question of the influence of the external electric field on the structure of the atom.

4. In the fourth part, we shall consider the question of the influence of the external magnetic field on the structure of the atom.

5. The fifth part of the paper is devoted to a discussion of the question of the influence of the external electric field on the structure of the atom.

6. In the sixth part, we shall consider the question of the influence of the external magnetic field on the structure of the atom.

7. The seventh part of the paper is devoted to a discussion of the question of the influence of the external electric field on the structure of the atom.

8. In the eighth part, we shall consider the question of the influence of the external magnetic field on the structure of the atom.

9. The ninth part of the paper is devoted to a discussion of the question of the influence of the external electric field on the structure of the atom.

AM ITEMS: 23 PART I, 27, PER NEO
FILM G-735 5/31/96 t.t

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 15716

Certificate of Death

Reg. No.

| | | | | | | | | | | |
|--|--|--|---|--|---|---|--|---|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
CHERYL CHAVIS-BLAKE | | | | 2. Date of Death
Month Day Year
APRIL 19, 1996 | | | | 3. Time of Death
01:21 A | |
| | 4a. Facility Name (If not institution, give street and number)
ANNE ARUNDEL GENERAL HOSPITAL | | | | 4b. City, Town, or Location of Death | | | | 4c. County of Death
ANNE ARUNDEL | |
| Funeral
Director | 5. Social Security Number
244 08 5875 | | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday)
37 Yrs. | | 8. Date of Birth (Month, Day, Year)
Oct, 4, 1958 | | 9. Birthplace (State or Foreign Country)
NC | |
| | Usual Residence of Decedent | | | | | | | | | |
| To Be Completed by Funeral Director | 10a. State
MD | | 10b. County
Anne Arundel | | 10c. City, Town or Location
Gambrills | | | | 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| | 10e. Street and Number
2037 Huntwood Drive | | | | 10f. Zip Code
21054 | | 10g. Citizen of What Country?
USA | | | |
| | 11. Marital Status
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc.
Specify: Black | | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4or 5+) <input checked="" type="checkbox"/> 5+ | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Mortgage Banker | | | 16b. Kind of Business/Industry
Non-Profit Org. | | |
| | 17. Father's Name (First, Middle, Last)
Edward Chavis | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Bernice Peebles | | | | | |
| | 19a. Informant's Name/Relationship (Type, Print)
Esau Blake Jr | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Same as 10 | | | | | |
| | 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Carolina Biblical | | Date
4/27/96 | | 20c. Location - City or Town, State
Raleigh, NC | | | |
| | 21. Signature of Funeral Service Licensee
 | | | | 22. Name and Address of Facility
GREENE FUNERAL HOME
814 Franklin Street
Alexandria, VA 22314 | | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death) MYOCARDITIS

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Due to (or as a consequence of):
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. | | | | | | | | | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | | |
| 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | | | | | | | | | |
| 24a. Was an autopsy performed?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | | | | |
| 25. Was case referred to medical examiner?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | | | | |
| 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | |
| 29a. Certifier (Check only one)
<input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | |
| 29b. Signature and title of certifier
 | | | | 29c. License number
OCME | | 29d. Date signed (Month, Day, Year)
APRIL 20, 1996 | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
David R Fowler 111 Penn Street, Baltimore, Maryland 21201 | | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
MAY 09 1996 | | | | | | | | | | |
| 32. Registrar's Signature
 | | | | | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

總之，以上各點均係根據本會所屬各機關、團體、學校、及社會服務機構之實際需要而擬定，其目的在使該項保險制度能真正發揮保障作用，並促進社會福利事業之發展。此致貴會鑒。

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 15717

Certificate of Death

Reg. No.

| | | | | | | | | |
|---|---|---|--|--|--|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Dorothy CLARK | | | | 2. Date of Death
Month Day Year
MAY 6, 1996 | | 3. Time of Death
6:35 PM | |
| | 4a. Facility Name (If not institution, give street and number)
Prince Georges County Hospital | | | | 4b. City, Town, or Location of Death
Cheverly | | 4c. County of Death
Prince Georges | |
| Funeral
Director | 5. Social Security Number
321-12-5125 | | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)
83 Yrs. | If Under 1 Year
Month Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth (Month, Day, Year)
Apr. 1, 1913 | 9. Birthplace (State or Foreign Country)
Tupelo, Miss. |
| | Usual Residence of Decedent | | | | | | | |
| 10a. State
Md. | | 10b. County
Prince Georges | | 10c. City, Town or Location
Ft. Washington | | | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | |
| 10e. Street and Number
8919 Rusland Ct. | | | | 10f. Zip Code
20744 | | 10g. Citizen of What Country?
U.S.A. | | |
| 11. Marital Status
<input type="checkbox"/> Navar Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc.
Specify: Black | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 8 College (1-4or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Elevator Operator | | | 16b. Kind of Business/Industry
Private Industry | |
| 17. Father's Name (First, Middle, Last)
Austin W. Sullivan | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Emma Edwards | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
Denise Clark | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
8919 Rusland Ct., Ft. Washington, Md., 20744 | | | | |
| 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Highland Park Cem. | | Date
5/11/96 | | 20c. Location - City or Town, State
Cleveland, Ohio | | |
| 21. Signature of Funeral Service Licensee
 | | | | 22. Name and Address of Facility
Frazier Funeral Home, Inc.
389 Rhode Island Av., N.W., Washington, D.C. 20001 | | | | |
| 23a. Part I. Enter the disease or complication(s) that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. LARGE RIGHT CEREBRAL INFARCT 10 days
Due to (or as a consequence of):
b. SYSTEMIC EMBOLIZATION 14 days
Due to (or as a consequence of):
c. CHRONIC ATRIAL FIBRILLATION 10 YRS
Due to (or as a consequence of):
d. CONGESTIVE HEART FAILURE 10 YRS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | | Approximate Interval Between Onset and Death |
| Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I.
RENAL FAILURE
DIABETIC NEPHROPATHY
PERIPHERAL VASCULAR DISEASE | | | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | |
| 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier
 | | | | | | |
| 29c. License number
D 28195 (MD) | | 29d. Date signed (Month, Day, Year)
5-7-96 | | | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
DAVID A. GOORAY, MD, 12164 CENTRAL AVE. MITCHELLVILLE MD, 20721 | | | | | | | | |
| 31. Date filed (Month, Day, Year)
MAY 09 1996 | | 32. Registrar's Signature
 | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Clark

Journal of Management Education 30(6)

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State of Maryland / Department of Health and Mental Hygiene

96 15718

Certificate of Death

Reg. No.

| | | | | | | | | |
|---|--|--|--|--|---|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Ragnhild Severud Cobleigh | | | | 2. Date of Death
Month Day Year
May 08, 1996 | | 3. Time of Death
8:55 AM | |
| | 4a. Facility Name (If not institution, give street and number)
4013 Calvert Avenue | | | | 4b. City, Town, or Location of Death
Chesapeake Beach | | 4c. County of Death
Calvert | |
| Funeral
Director | 5. Social Security Number
543-46-9708 | | 6. Sex
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday)
70 Yrs. | | 8. Date of Birth (Month, Day, Year)
Dec. 4, 1925 | |
| | 9. Birthplace (State or Foreign Country)
Norway | | 10a. State
Maryland | | 10b. County
Calvert | | 10c. City, Town or Location
Chesapeake Beach | |
| To Be Completed by Funeral Director | 10d. Inside City Limits
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 10e. Street and Number
4013 Calvert Avenue | | 10f. Zip Code
20732 | | 10g. Citizen of What Country?
USA | |
| | 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: White | |
| To Be Completed by Physician/Medical Examiner | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12)
12 | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Director | | 16b. Kind of Business/Industry
Day Care | | 17. Father's Name (First, Middle, Last)
Petrus Valentin Giortz | |
| | 17. Mother's Name (First, Middle, Maiden Surname)
Hildur Marie Severud | | 18. Informant's Name/Relationship (Type, Print)
Herbert N. Cobleigh/Husband | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
P.O. Box 1003 Chesapeake Beach, MD 20732 | | 20a. Method of Disposition
1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | |
| Physician
/Medical
Examiner | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Metropolitan Crematory | | 20c. Date
5/9/96 | | 20d. Location - City or Town, State
Alexandria, VA | | 21. Signature of Funeral Service Licensee
Spencer E. Sawell | |
| | 22. Name and Address of Facility
Sewell Funeral Home
1451 Dares Beach Rd. Prince Frederick, MD 20678 | | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
Immediate Cause (Final disease or condition resulting in death)
Metastatic Colon Carcinoma
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
Due to (or as a consequence of):
Due to (or as a consequence of): | | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | |
| To Be Completed by Physician/Medical Examiner | 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide
5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | |
| | 28a. Date of injury (Month, Day Year)
28b. Time of injury
M
28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
28d. Describe how injury occurred
28e. Location (Street and Number or Rural Route Number, City or Town, State) | | 29a. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier
Jonathan Lowenthal, M.D. | | 29c. License number
033123 | |
| State Registrar | 29d. Data signed (Month, Day, Year)
5-8-96 | | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Jonathan Lowenthal, M.D.
Dunkirk, MD | | 31. Date filed (Month, Day, Year)
MAY 10 1996 | | 32. Registrar's Signature
Davidson-Randall | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 24a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1. The first part of the document discusses the importance of maintaining accurate records of all transactions. It emphasizes that proper record-keeping is essential for the integrity of the financial system and for the ability to detect and prevent fraud.

2. The second part of the document outlines the specific procedures for recording transactions. It details the steps involved in the accounting process, from the initial entry of data into the system to the final review and approval of the records.

3. The third part of the document addresses the role of the accounting department in ensuring the accuracy of the records. It describes the various checks and balances that are in place to ensure that all transactions are properly recorded and that the system is secure.

4. The fourth part of the document discusses the importance of regular audits and reviews. It explains how these processes help to identify any discrepancies or errors in the records and to ensure that the system is operating as intended.

5. The fifth part of the document provides a summary of the key points discussed in the previous sections. It reiterates the importance of accurate record-keeping and the need for strict adherence to the established procedures.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 15719

Certificate of Death

Reg. No.

Physician
/Medical
ExaminerFuneral
Director

1. Decedent's Name (First, Middle, Last)

Allan Leigh Curtin

2. Date of Death

Month Day Year

May 6, 1996

3. Time of Death

0044

4a. Facility Name (If not institution, give street and number)

Calvert Memorial Hospital

4b. City, Town, or Location of Death

Prince Frederick

4c. County of Death

Calvert

5. Social Security Number

579-52-2523

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

56 Yrs.

If Under 1 Year

Montha Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

Feb 24, 1940

9. Birthplace (State or Foreign Country)

Wash., D.C.

Usual Residence of Decedent

10a. State

Maryland

10b. County

Calvert

10c. City, Town or Location

Dunkirk

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

11131 Dumbarton Drive

10f. Zip Code

20754

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: white

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

Collega (14 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working
life. DO NOT use retired)

driver / salesman

16b. Kind of Business/Industry

food services

17. Father's Name (First, Middle, Last)

Allan N. Curtin

18. Mother's Name (First, Middle, Maiden Surname)

Mildred Elizabeth Bobbitt

19a. Informant's Name/Relationship (Type, Print)

Mrs. Rosemary Curtin/spouse

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

same as # 10 above

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

So. Memorial Gardens

Date

5/9/96

20c. Location - City or Town, State

Dunkirk, MD

21. Signature of Funeral Service Licensee

William R. Rausch

22. Name and Address of Facility

Rausch Funeral Home, P.A., Owings, MD

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)a. Coronary Artery Disease
Died to (or as a consequence of):

b. Died to (or as a consequence of):

c. Died to (or as a consequence of):

d. Died to (or as a consequence of):

Sequently list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) LastApproximate
Interval Between
Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☒ Yes 2 ☐ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☒ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☒ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
2 ☐ Accident 6 ☐ Could not be
3 ☐ Suicide 6 ☐ investigation
4 ☐ Homicide 6 ☐ determined

28a. Date of Injury

(Month, Day Year)

28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

Mark J. Kushner, M.D.

29c. License number

D23468

29d. Date signed (Month, Day, Year)

5/6/96

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Mark J. Kushner, M.D., Prince Frederick, MD 20678

31. Date filed (Month, Day, Year)

MAY 10 1996

32. Registrar's Signature

John A. Anderson-Randall

State
Registrar

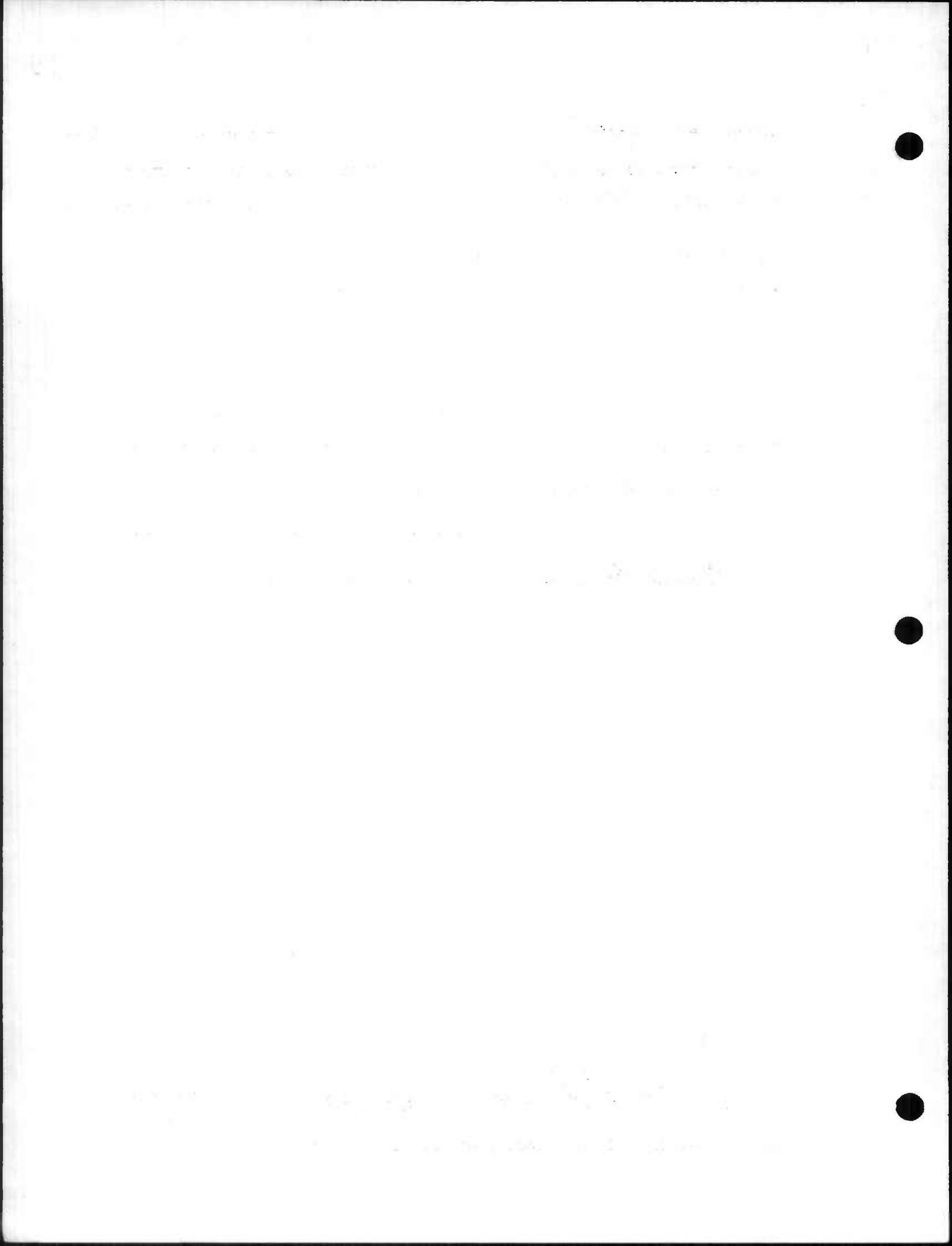
Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 15720

Certificate of Death

Reg. No.

| | | | | | | | | |
|--|---|--|---|--|--|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Earl Cooper | | | | 2. Date of Death
Month May Day 05 Year 1996 | | 3. Time of Death
4:00 pm | |
| | 4a. Facility Name (If not institution, give street and number)
Washington Adventist Hospital | | | | 4b. City, Town, or Location of Death
Takoma Park | | 4c. County of Death
Montgomery | |
| Funeral
Director | 5. Social Security Number
579-88-6159 | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday)
34 Yrs. | | 8. Date of Birth (Month, Day, Year)
07-22-61 | |
| | 9. Birthplace (State or Foreign Country)
Sumter, SC | | | | | | | |
| To Be Completed by Funeral Director | Usual Residence of Decedent | | | | | | | |
| | 10a. State
Maryland | | 10b. County
Prince George's | | 10c. City, Town or Location
Capitol Heights | | | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |
| | 10e. Street and Number
305 Milfan Drive | | | | 10f. Zip Code
20743 | | 10g. Citizen of What Country?
USA | |
| | 11. Marital Status
<input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: Black | |
| | 15. Decedent's Education (Specify only highest grade completed)
12th | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Food Service Worker | | 16b. Kind of Business/Industry
Private | | | |
| | 17. Father's Name (First, Middle, Last)
Nathaniel Timothy | | | | 18. Mother's Name (First, Middle, Maiden Summa)
Lorine Cooper | | | |
| | 19a. Informant's Name/Relationship (Type, Print)
Lorine Wilson/Mother | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
305 Milfan Drive, Capitol Heights, MD 20743 | | | |
| | 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Harmony Memorial Park | | Date
5/9/96 | | 20c. Location - City or Town, State
Landover, MD | |
| | 21. Signature of Funeral Service Licensee
Spumvelly C Busck-Tone | | | | 22. Name and Address of Facility
J. B. Jenkins Funeral Home
7474 Landover Road, Landover, MD 20785 | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | |
| Physician
/Medical
Examiner | Immediate Cause (Final disease or condition resulting in death) | | | | | | Approximate Interval Between Onset and Death | |
| | a. Septicemia
Due to (or as a consequence of): | | | | | | Six days | |
| | b. Renal Failure
Due to (or as a consequence of): | | | | | | Six days | |
| | c. Acquired Immune Deficiency Syndrome
Due to (or as a consequence of): | | | | | | Several years | |
| Medical Certification: To Be Completed by Physician/Medical Examiner | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | |
| | | | | | | | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No | |
| | 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| | 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input type="checkbox"/> No | |
| | | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28d. Describe how Injury occurred | | | |
| | | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| | 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier
M Karim MD | | 29c. License number
D-18895 | | 29d. Date signed (Month, Day, Year)
May 05, 1996 | |
| | 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)
Mobarak Karim 7610 Carroll Avenue, Takoma Park, MD 20912 | | | | | | | |
| | 31. Date filed (Month, Day, Year)
MAY 09 1996 | | 32. Registrar's Signature
John H. ... | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

96 15721

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
PAULINE SCHWARTEN CLOUGH | | | | 2. DATE OF DEATH
MONTH MAY DAY 13 YEAR 1996 | | 3. TIME OF DEATH
8:00 AM | |
| 4. SOCIAL SECURITY NUMBER
218-24-4866 | | 5. SEX
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
70 YRS. | | 7. DATE OF BIRTH
(Month, Day, Year)
FEB. 27, 1926 | |
| 8. BIRTHPLACE (State or Foreign Country)
MARYLAND | | 9a. FACILITY NAME (If not institution, give street and number)
11170 CHAPEL ROAD | | 9b. CITY, TOWN OR LOCATION OF DEATH
CORDOVA | | 9c. COUNTY OF DEATH
TALBOT | |
| 10a. STATE
MARYLAND | | 10b. COUNTY
TALBOT | | 10c. CITY, TOWN OR LOCATION
CORDOVA | | 10d. INSIDE CITY LIMITS?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 10e. STREET AND NUMBER
11170 CHAPEL ROAD | | 10f. ZIP CODE
21625 | | 10g. CITIZEN OF WHAT COUNTRY?
USA | | | |
| 11. MARITAL STATUS
1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify: WHITE | |
| 15. DECEDENT'S EDUCATION
(Specify only highest grade completed)
Elementary/Secondary (0-12) 11 College (1-4 or 5+) | | 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.)
HOMEMAKER | | 16b. KIND OF BUSINESS/INDUSTRY
OWN HOME | | | |
| 17. FATHER'S NAME (First, Middle, Last)
JULIUS GEORGE SCHWARTEN | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
BERTHA REBECCA HARTZ | | | |
| 19a. INFORMANT'S NAME (Type/Print)
GEORGE E. CLOUGH | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
11170 CHAPEL ROAD, CORDOVA, MD 21625 | | | |
| 20a. METHOD OF DISPOSITION
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
MD. VETERAN CEMETERY 5-16 | | 20c. LOCATION — City or Town, State
BEULAH, MD | | 20d. DATE | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
<i>B. Keet Phypers, CFSP</i> | | | | 22. NAME AND ADDRESS OF FACILITY
FELLOWS, HELFENBEIN & NEWMAN FUNERAL
200 S. HARRISON ST., EASTON, MD | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | | a. <i>end stage renal disease</i>
DUE TO (OR AS A CONSEQUENCE OF): | | | | Approximate Interval Between Onset and Death
2 1/2 MONTHS | |
| Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST | | b. <i>pneumonia</i>
DUE TO (OR AS A CONSEQUENCE OF): | | | | | |
| | | c.
DUE TO (OR AS A CONSEQUENCE OF): | | | | | |
| | | d.
DUE TO (OR AS A CONSEQUENCE OF): | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/> | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M | | 28c. INJURY AT WORK?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| | | 28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28e. DESCRIBE HOW INJURY OCCURRED | | | |
| 29a. CERTIFIER (Check only one)
1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. SIGNATURE AND TITLE OF CERTIFIER
<i>Kathleen Hoyer</i> | | 29c. LICENSE NUMBER
D47627 | | 29d. DATE SIGNED (Month, Day, Year)
05-15-96 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
<i>Kathleen Hoyer 207 N. Liberty St B Centerville Md 21617</i> | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
MAY 16 1996 | | 32. REGISTRAR'S SIGNATURE
<i>John Andrew Randall</i> | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 15722

Certificate of Death

Reg. No.

| | | | | | | | | |
|--|---|---|--|---|--|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
JAMES DANIELS | | | | 2. Date of Death
Month Day Year
May 1, 1996 | | 3. Time of Death
3:25 P.M. | |
| | 4a. Facility Name (If not institution, give street and number)
ALLEGIS HEALTH & REHABILITATION CENTER | | | | 4b. City, Town, or Location of Death
Silver Spring | | 4c. County of Death
Montgomery | |
| Funeral
Director | 5. Social Security Number
419-12-6976 | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)
75 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth (Month, Day, Year)
Dec. 7, 1920 | 9. Birthplace (State or Foreign Country)
Alabama |
| | Usual Residence of Decedent | | | | | | | |
| 10a. State
Maryland | | 10b. County
Montgomery | | 10c. City, Town or Location
Silver Spring | | | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | |
| 10e. Street and Number
901 Arcola Avenue | | | | 10f. Zip Code
20902 | | 10g. Citizen of What Country?
United State | | |
| 11. Marital Status
<input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: Black | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input checked="" type="checkbox"/> 2 | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Clerical | | 18b. Kind of Business/Industry
Private | | |
| 17. Father's Name (First, Middle, Last)
Charles Daniels | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Emma Williams | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
Sebrevia D. Davis | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
4827 8th Street, N.E., Washington, D. C. 20017 | | | | |
| 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Harmony Memorial Park | | Date
5/4/96 | | 20c. Location - City or Town, State
Landover, Maryland | | |
| 21. Signature of Funeral Service Licensee
<i>John T. Stewart III</i> | | | | 22. Name and Address of Facility
STEWART FUNERAL HOME, INC.
4001 Benning Road, N.E., Washington, D. C. | | | | |
| 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. Pancreatic Carcinoma
Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last | | | | | | | | Approximate Interval Between Onset and Death
4 mos. |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Arteriosclerotic Cardiovascular Disease
Diabetes mellitus | | | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | |
| | | | | | | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation
<input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined
<input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred |
| | | 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier
<i>[Signature]</i> | | | | | | |
| | | 29c. License number
D41931 | | 29d. Date signed (Month, Day, Year)
May 2, 1996 | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
R Shomacher MD 2309 Shorefield Road Wheaton, MD 20902 | | | | | | | | |
| 31. Date filed (Month, Day, Year)
MAY 07 1996 | | 32. Registrar's Signature
<i>John Shomacher</i> | | | | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

1. The first part of the paper is devoted to the study of the properties of the function $f(x)$ defined by the equation

$$f(x) = \int_0^x \frac{1}{1+t^2} dt$$

It is well known that this function is the arctangent function, i.e. $f(x) = \arctan x$. The main result of this section is the following theorem:

Theorem 1. Let $f(x)$ be the function defined by the equation (1). Then for any $x \in \mathbb{R}$ the following inequality holds:

$$|f(x)| \leq \frac{1}{2} \ln(1+x^2)$$

The proof of this theorem is given in the next section. In the following section we will study the properties of the function $f(x)$ and its derivatives.

2. In the second part of the paper we study the properties of the function $f(x)$ and its derivatives. It is well known that the function $f(x)$ is an odd function, i.e. $f(-x) = -f(x)$.

3. In the third part of the paper we study the properties of the function $f(x)$ and its derivatives. It is well known that the function $f(x)$ is a concave function, i.e. $f''(x) < 0$.

4. In the fourth part of the paper we study the properties of the function $f(x)$ and its derivatives. It is well known that the function $f(x)$ is a bounded function, i.e. $|f(x)| < \infty$.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 15723

Certificate of Death

Reg. No.

Physician
/Medical
ExaminerFuneral
Director

| | | | | | | | | | | | | | | | | | |
|---|--|---|--|--|--------------------------------|--|--|---|--------------------------------|---|---|--------------------|---------------|-------------------------|----------------|-----------------------------------|----------------|
| 1. Decedent's Name (First, Middle, Last)
Lawrence Bruce Daniels | | | | 2. Date of Death
May 1, 1996 Year | | 3. Time of Death
10:07A | | | | | | | | | | | |
| 4a. Facility Name (If not institution, give street and number)
Doctors' Community Hospital | | | | 4b. City, Town, or Location of Death
Lanham | | 4c. County of Death
Prince George's | | | | | | | | | | | |
| 5. Social Security Number
478 32 9680 | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)
63 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth (Month, Day, Year)
Jan. 20, 1933 | | | | | | | | | | | |
| 9. Birthplace (State or Foreign Country)
Iowa | | | | | | | | | | | | | | | | | |
| Usual Residence of Decedent | | | | | | | | | | | | | | | | | |
| 10a. State
Maryland | | 10b. County
Prince George's | | 10c. City, Town or Location
Bowie | | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | | | | | |
| 10e. Street and Number
4017 Welsley Lane | | | | 10f. Zip Code
20715 | | 10g. Citizen of What Country?
United States | | | | | | | | | | | |
| 11. Marital Status
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
If Yes, Give Year or Dates: Vietnam | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: White | | | | | | | | | | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 4 College (1-4 or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Manager Department of Labor | | 16b. Kind of Business/Industry
U.S. Government | | | | | | | | | | | |
| 17. Father's Name (First, Middle, Last)
Robert Walter Daniels | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Dorothy M. Rowley | | | | | | | | | | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
Joyce M. Daniels Wife | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
4017 Welsley Lane Bowie Maryland 20715 | | | | | | | | | | | | | |
| 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Lakemont Memorial Gardens | | Date
5/4/96 | | 20c. Location - City or Town, State
Davidsonville Md. | | | | | | | | | | | |
| 21. Signature of Funeral Service Licensee
Robert E. Evans Pro | | | | 22. Name and Address of Facility
Robert E. Evans Funeral Home, P.A.
16000 Annapolis Rd. Bowie Maryland 20715 | | | | | | | | | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

<table border="0"> <tr> <td>Immediate Cause (Final disease or condition resulting in death)</td> <td>a. ASPIRATION PNEUMONIA</td> <td>Approximate Interval Between Onset and Death
4 DAYS</td> </tr> <tr> <td rowspan="4">Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last</td> <td>b. VOMITING</td> <td>4 DAYS</td> </tr> <tr> <td>c. GASTROPARESIS</td> <td>10 DAYS</td> </tr> <tr> <td>d. GRAM NEGATIVE UROSEPSIS</td> <td>10 DAYS</td> </tr> </table> | | | | | | | | Immediate Cause (Final disease or condition resulting in death) | a. ASPIRATION PNEUMONIA | Approximate Interval Between Onset and Death
4 DAYS | Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last | b. VOMITING | 4 DAYS | c. GASTROPARESIS | 10 DAYS | d. GRAM NEGATIVE UROSEPSIS | 10 DAYS |
| Immediate Cause (Final disease or condition resulting in death) | a. ASPIRATION PNEUMONIA | Approximate Interval Between Onset and Death
4 DAYS | | | | | | | | | | | | | | | |
| Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last | b. VOMITING | 4 DAYS | | | | | | | | | | | | | | | |
| | c. GASTROPARESIS | 10 DAYS | | | | | | | | | | | | | | | |
| | d. GRAM NEGATIVE UROSEPSIS | 10 DAYS | | | | | | | | | | | | | | | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
GRAM NEGATIVE UROSEPSIS, UNCONTROLLED
DIABETES MELLITUS, HYPEROSMOLAR DEHYDRATION
ACUTE RENAL FAILURE, PNEUMOTHORAX | | | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | | | | | | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | | | | | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation
<input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined
<input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | | | | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28d. Describe how injury occurred | | | | | | | | | | | | | |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | | | | |
| 29b. Signature and title of certifier
Napoleon C. Marcelo, MD | | | | 29c. License number
D31345 | | 29d. Date signed (Month, Day, Year)
5-1-96 | | | | | | | | | | | |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)
Dr. Napoleon C. Marcelo 4000 Mitchellville Rd., Suite 430B Bowie, MD 20716 | | | | | | | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
MAY 08 1996 | | | | | | | | | | | | | | | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

96 15724

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
CAYETANO HERNANDO DOMINGO | | | | 2. DATE OF DEATH
MONTH MAY DAY 7 YEAR 1996 | | 3. TIME OF DEATH
12:30 A | |
| 4. SOCIAL SECURITY NUMBER
577-52-0773 | | 5. SEX
1 <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
91 YRS. | | 7. DATE OF BIRTH (Month, Day, Year)
4-10-1905 | |
| 8. BIRTHPLACE (State or Foreign Country)
Philippines | | | | 9a. FACILITY NAME (If not institution, give street and number)
6906 Loch Raven Rd. | | 9b. CITY, TOWN OR LOCATION OF DEATH
Camp Springs | |
| 9c. COUNTY OF DEATH
PRINCE GEORGE'S | | | | 10a. STATE
Maryland | | 10b. COUNTY
Prince George's | |
| 10c. CITY, TOWN OR LOCATION
Camp Springs | | | | 10d. INSIDE CITY LIMITS?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 10e. STREET AND NUMBER
6906 Loch Raven Rd. | |
| 10f. ZIP CODE
20748 | | | | 10g. CITIZEN OF WHAT COUNTRY?
USA | | 11. MARITAL STATUS
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced | |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO
IF YES, GIVE WAR OR DATES
1925 to 1955 | | | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | | |
| 14. RACE — American Indian, Black, White, etc.
Specify: Asian | | | | 15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12) 7th College (1-4 or 5+) U.S. Navy- Chief | | | |
| 16. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
Military | | | | 17. FATHER'S NAME (First, Middle, Last)
Fernando Domingo | | | |
| 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Lucia Hernando | | | | 19a. INFORMANT'S NAME (Type/Print)
Michael Sabino | | | |
| 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1800 Maple Ln. Accokeek, Maryland 20607 | | | | 20a. METHOD OF DISPOSITION
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | |
| 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
Arlington Nat'l Cemetery 5-17-96 Arlington, Virginia | | | | 20c. LOCATION — City or Town, State | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
<i>[Signature]</i> | | | | 22. NAME AND ADDRESS OF FACILITY
George P. Kalas Funeral Home
6160 Oxon Hill Rd. Oxon Hill, Md. 20745 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | | a. Generalized Atherosclerotic Cardio-Vascular Disease | | | | Approximate Interval Between Onset and Death
years. | |
| Due to (or as a consequence of): | | b. DUE TO (OR AS A CONSEQUENCE OF): | | | | | |
| Due to (or as a consequence of): | | c. DUE TO (OR AS A CONSEQUENCE OF): | | | | | |
| Due to (or as a consequence of): | | d. DUE TO (OR AS A CONSEQUENCE OF): | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Chronic obstructive Pulmonary Disease | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
<input type="checkbox"/> YES <input type="checkbox"/> NO | | | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation
<input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M | | 28c. INJURY AT WORK?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 28d. DESCRIBE NOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one)
<input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
<i>[Signature]</i> MD | | | | 29c. LICENSE NUMBER
025925 | | 29d. DATE SIGNED (Month, Day, Year)
May 7, 1996 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
J. BERGER MD #205, 7720 Wisconsin Ave, Bethesda, Md 20814 | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
MAY 09 1996 | | 32. REGISTRAR'S SIGNATURE
<i>[Signature]</i> | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 15725

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

ALOYSIUS E. DOUGHERTY

2. Date of Death
Month Day Year

5 6 1996

3. Time of Death

7:42 AM

Funeral
Director

4a. Facility Name (If not institution, give street and number)

ATLANTIC GENERAL HOSPITAL

4b. City, Town, or Location of Death

BERLIN

4c. County of Death

WORCESTER

5. Social Security Number

170-22-8999

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

67

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

MARCH 2, 1929

9. Birthplace (State or Foreign Country)

PENNSYLVANIA

Usual Residence of Decedent

10a. State

DELAWARE

10b. County

SUSSEX

10c. City, Town or Location

DAGSBORO

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

29 MANOR DRIVE, MALLARD CREEK

10f. Zip Code

19939

10g. Citizen of What Country?

USA

11. Marital Status

☐ Never Married ☒ Married
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

☒ Yes ☐ No
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)☐ Yes ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: WHITE

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

HVAC TECHNICIAN

16b. Kind of Business/Industry

HEATING AND
AIR CONDITIONING

17. Father's Name (First, Middle, Last)

JOSEPH DOUGHERTY

18. Mother's Name (First, Middle, Maiden Surname)

GERTRUDE GENSHIEMER

19a. Informant's Name/Relationship (Type, Print)

JEAN M. DOUGHERTY-WIFE

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

29 MALLARD DR., MALLARD CREEK, DAGSBORO, DE. 19939

20a. Method of Disposition

☐ Burial ☐ Cremation ☐ Removal from State
☐ Donation ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

CAREY'S CEMETERY

Date

5/9/96

20c. Location - City or Town, State

FRANKFORD, DELAWARE

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

MELSON FUNERAL SERVICES
FRANKFORD, DE. 1994523a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)a. Cardiac arrest
Due to (or as a consequence of):b. Coronary atherosclerosis
Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) LastApproximate
Interval Between
Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

- mild A. stenosis

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☐ No ☐ Probably ☒ Unknown24a. Was an autopsy
performed?☐ Yes ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?☐ Yes ☐ No25. Was case referred to medical
examiner?☐ Yes ☒ No

Hospital:

☒ Inpatient☐ ER/Outpatient☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

☒ Natural 5 ☐ Pending
investigation
☐ Accident 6 ☐ Could not be
determined
☐ Suicide
☐ Homicide28a. Date of Injury
(Month, Day Year)28b. Time of
Injury28c. Injury at
Work?☐ Yes ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D 25036

29d. Date signed (Month, Day, Year)

5/9/96

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

D H.R. Hoelz - 614 D Eastern Shore Drive - SALISBURY.

31. Date filed (Month, Day, Year)

MAY 08 1996

32. Registrar's Signature

John Anderson-Rodell

State
Registrar

Baltimore, Maryland 21215-0020

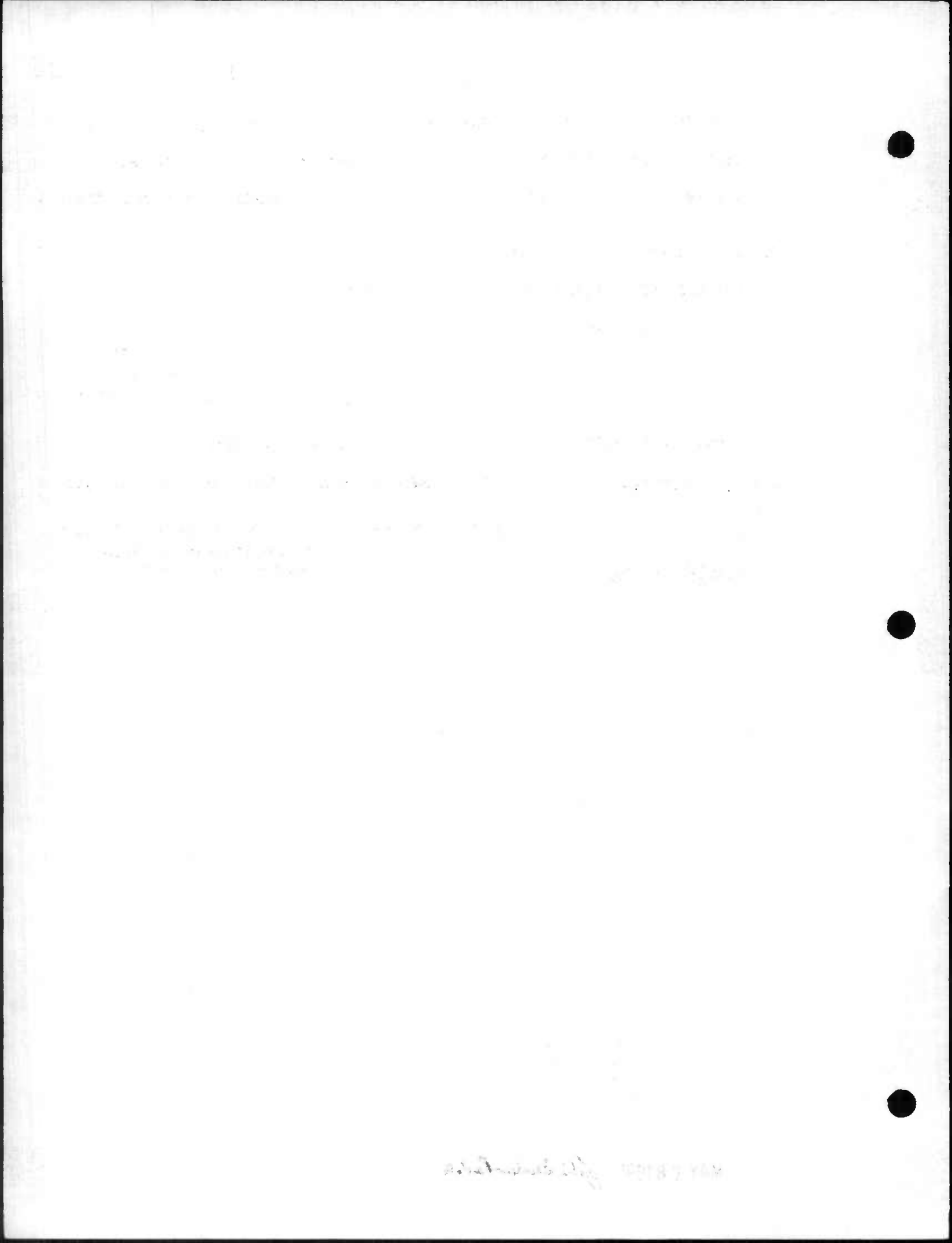
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.



96 15726

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|---|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
MARGARET CATHERINE EVANS | | | | 2. DATE OF DEATH
MONTH 5 DAY 15 YEAR 96 | | 3. TIME OF DEATH
9:20 A M | |
| 4. SOCIAL SECURITY NUMBER
220-18-0392 | | 5. SEX
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | 6. AGE (in yrs. last birthday)
76 YRS. | 7. DATE OF BIRTH (Month, Day, Year)
JAN. 2, 1920 | | 8. BIRTHPLACE (State or Foreign Country)
MARYLAND | |
| 9a. FACILITY NAME (If not institution, give street and number)
LONG VIEW NURSING HOME | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
MANCHESTER | | 9c. COUNTY OF DEATH
CARROLL | |
| 10a. STATE
MARYLAND | | | | 10b. COUNTY
CARROLL | | 10c. CITY, TOWN OR LOCATION
FINKSBURG | |
| 10d. INSIDE CITY LIMITS?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | 10e. STREET AND NUMBER
731 RIDGE RD. | | | |
| 10f. ZIP CODE
21048 | | | | 10g. CITIZEN OF WHAT COUNTRY?
USA. | | | |
| 11. MARITAL STATUS
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify: WHITE | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12) 6 College (1-4 or 5+) 6 | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
HOUSEWIFE | | 16b. KIND OF BUSINESS/INDUSTRY
HOME MAKING | | | |
| 17. FATHER'S NAME (First, Middle, Last)
CARROLL F. FORD, SR. | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
VIRGIE HOFF | | | |
| 19a. INFORMANT'S NAME (Type/Print)
PATRICIA A. SISSON | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
731 RIDGE RD., FINKSBURG, MD. 21048 | | | |
| 20a. METHOD OF DISPOSITION
<input checked="" type="checkbox"/> Partial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
PATAPSCO U.M. CHURCH CEM 5/17 PATAPSCO, MD. | | 20c. LOCATION — City or Town, State | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
 | | | | 22. NAME AND ADDRESS OF FACILITY
FLETCHER FUNERAL HOME
254 E. MAIN ST., WESTMINSTER, MD. 21157 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. acute & chronic subdural HPMATOMA
DUE TO (OR AS A CONSEQUENCE OF):
Approximate interval Between Onset and Death 5 MON
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. DUE TO (OR AS A CONSEQUENCE OF):
c. DUE TO (OR AS A CONSEQUENCE OF):
d. | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Alzheimer's Dementia | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
<input type="checkbox"/> YES <input type="checkbox"/> NO | | | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation
<input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M | | 28c. INJURY AT WORK?
<input type="checkbox"/> YES <input type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one)
<input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
W. H. Howard M.D. | | | | 29c. LICENSE NUMBER
D02386 | | 29d. DATE SIGNED (Month, Day, Year)
5-15-96 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
W. H. FORD M.D. 3223 MAIN ST, MANCHESTER, MD 21102 | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
MAY 16 1996 | | | | 32. REGISTRAR'S SIGNATURE
 | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 15727

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

OLIVER L. EASON

2. Date of Death

April 30 1996

3. Time of Death

1:55 PM

4a. Facility Name (If not institution, give street and number)

Washington Adventist Hospital

4b. City, Town, or Location of Death

Takoma Park, MD

4c. County of Death

Montgomery

Funeral
Director

5. Social Security Number

240-34-8759

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

68

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

January 15, 1928

9. Birthplace (State or Foreign Country)

Smithfield, NC

Usual Residence of Decedent

10a. State

MD

10b. County

Prince Georges

10c. City, Town or Location

Hyattsville

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

2304 Rittenhouse Street

10f. Zip Code

20782

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☒ Yes 2 ☐ No
If Yes, Give Year or Dates: 11-4-52-4-8-54

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
7th

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Cabin Stewart

16b. Kind of Business/Industry

US Air

17. Father's Name (First, Middle, Last)

Ira Eason

18. Mother's Name (First, Middle, Maiden Surname)

Nellie Adams

19a. Informant's Name/Relationship (Type, Print)

Carolyn Eason Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2304 Rittenhouse St., Hyattsville, MD 20782

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Rock Creek Cemetery

Date

5-6-96

20c. Location - City or Town, State

Washington, DC

21. Signature of Funeral Service Licensee

J. P. Marshall

22. Name and Address of Facility

Marshall's Funeral Home, Inc.
4217 9th St. N.W., Wash., DC 20011

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, stroke, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Metastatic Lung Cancer
Due to (or as a consequence of):

Approximate Interval Between Onset and Death

9 months

Sequitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ OOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Physician2 ☐ Medical Examiner

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

John A. Bensing MD

29c. License number

D08754

29d. Date signed (Month, Day, Year)

April 30, 1996

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

THOMAS A. BENSINGER 7525 GREENWAY CR. DR. GREENBELT MD 20770

31. Date filed (Month, Day, Year)

MAY 06 1996

32. Registrar's Signature

John A. Bensing

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permitted. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

(5)

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 15728

Certificate of Death

Reg. No.

| | | | | | | | | | |
|---|---|---|---|--|--|--|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
EDITH FILSON | | | | 2. Date of Death
Month MAY Day 2 Year 1996 | | 3. Time of Death
0806 | | |
| | 4a. Facility Name (If not institution, give street and number)
NORTHWEST HOSPITAL CENTER | | | | 4b. City, Town, or Location of Death
RANDALLSTOWN | | 4c. County of Death
BALTIMORE | | |
| Funeral
Director | 5. Social Security Number
412-02-0614 | | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)
72 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth (Month, Day, Year)
7/28/23 | 9. Birthplace (State or Foreign Country)
Tenn. | |
| | 10a. State
Md | | 10b. County
Baltimore | | 10c. City, Town or Location
Owings Mills | | 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| To Be Completed by Funeral Director | 10e. Street and Number
107 WILLOW BEND DRIVE #3A | | | | 10f. Zip Code
21117 | | 10g. Citizen of What Country?
USA | | |
| | 11. Marital Status
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify BLACK | | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 Yrs | | College (1-4 or 5+) 4 Yrs | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
EDUCATOR | | 18b. Kind of Business/Industry
EDUCATION | | |
| | 17. Father's Name (First, Middle, Last)
JAMES LUTHER FEARN | | | | 18. Mother's Name (First, Middle, Maiden Surname)
MARIE WASHINGTON | | | | |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print)
HAROLD FILSON | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
SAME AS 10A,B,C,D,E&F | | | | |
| | 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Harmony Memorial | | Date
5/8/96 | | 20c. Location - City or Town, State
Landover, Md. | | |
| | 21. Signature of Funeral Service Licensee
<i>Juan Smith</i> | | | | 22. Name and Address of Funeral Home
JOHN T. RHINES CO., INC.
3030 12th ST NE, DC 20017 | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. RESPIRATORY FAILURE
Due to (or as a consequence of):
b. ASPIRATION
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | | |
| | | | | | | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | |
| | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how Injury occurred | |
| | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | | |
| 29b. Signature and title of certifier
<i>C. Ravi MD</i> | | | | 29c. License number
D37333 | | 29d. Date signed (Month, Day, Year)
MAY 2, 1996 | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
C. RAVI, MD, NHC, BALTO. MD 21133 | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
MAY 07 1996 | | 32. Registrar's Signature
<i>[Signature]</i> | | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 15729

Certificate of Death

Reg. No.

| | | | | | | | | |
|--|---|--|--|--|---|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
LOWELL EDWARD FLOWERS | | | | 2. Date of Death
Month 10 Day 19 Year 1996 | | 3. Time of Death
2315 | |
| | 4a. Facility Name (If not institution, give street and number)
CALVERT MEMORIAL HOSPITAL | | | | 4b. City, Town, or Location of Death
PRINCE FREDERICK | | 4c. County of Death
CALVERT | |
| Funeral
Director | 5. Social Security Number
233 10 0337 | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday)
85 Yrs. | | 8. Date of Birth (Month, Day, Year)
March 2 1911 | |
| | 10a. State
Maryland | | 10b. County
Calvert | | 10c. City, Town or Location
Sunderland Charleston | | 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| To Be Completed by Funeral Director | 10e. Street and Number
6015 Gordon Drive | | | | 10f. Zip Code
20689 | | 10g. Citizen of What Country?
United States | |
| | 11. Marital Status
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
If Yes, Give Year or Dates: unt | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify White | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12
College (1-4 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
grocery sales | | 16b. Kind of Business/Industry
Lewis Hubbard | | | |
| | 17. Father's Name (First, Middle, Last)
Madison E. Flowers | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Florence Elkins | | | |
| | 19a. Informant's Name/Relationship (Type, Print)
Murhl Flowers / | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
6015 Gordon Drive Sunderland Md. 20689 | | | |
| | 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Jones- Flowers Cemetery | | 20c. Location - City or Town, State
Big Sandy West Virgi | | | |
| | 21. Signature of Funeral Service Licensee
B. Rausch | | | | 22. Name and Address of Facility
Rausch Funeral Home
4405 Broomes Is. RD. Port Republic MD | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. Coronary Artery disease
Due to (or as a consequence of):

b.
Due to (or as a consequence of):

c.
Due to (or as a consequence of):

d.
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | |
| | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown | | | | | | | |
| | 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | | |
| Medical Certification: To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one)
Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | |
| | 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation
2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined
3 <input type="checkbox"/> Suicidal 4 <input type="checkbox"/> Homicidal | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| | 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28d. Describe how injury occurred | | | |
| | 28e. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| | 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | |
| | 29b. Signature and title of certifier
Jahriyonsany M.D. | | | | 29c. License number
D27189 | | 29d. Date signed (Month, Day, Year)
5/11/96 | |
| | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
ZAHIR YOUSAF, M.D. P.O BOX 1289 WALDORF, M.D 20604 | | | | | | | |
| | 31. Date filed (Month, Day, Year)
MAY 13 1996 | | | | 32. Registrar's Signature
Jahriyonsany | | | |
| | State Registrar | | | | | | | |

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 15730

Physician
/Medical
ExaminerFuneral
Director

1. Decedent's Name (First, Middle, Last)

FRANCES RICE FUCHS

2. Date of Death

Month Day Year
April 23, 1996

3. Time of Death

10:05AM

4a. Facility Name (If not institution, give street and number)

Hebrew Home Of Greater Washington

4b. City, Town, or Location of Death

Rockville

4c. County of Death

Montgomery

5. Social Security Number

579-48-3918

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

88 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
6/29/1907

9. Birthplace (State or Foreign Country)

New York

Usual Residence of Decedent

10a. State

MD

10b. County

Montgomery

10c. City, Town or Location

Rockville

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

6121 Montrose Road

10f. Zip Code

20852

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

5+

16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Educator

16b. Kind of Business/Industry

School

17. Father's Name (First, Middle, Last)

Arthur Rice

18. Mother's Name (First, Middle, Maiden Surname)

Laura Wise

19a. Informant's Name/Relationship (Type, Print)

Peter R. Fuchs

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

5405 Carolina Pl., N.W. Wash, D.C. 20016

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☒ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Georgetown Med. Sch. 4/23/96 Washington, D.C.

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Austin Royster Funeral Home
3605 14th St. N.W., Wash, DC. 20010

23. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate
Interval Between
Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Cerebrovascular Accident

Due to (or as a consequence of):

Years

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Coronary Artery Disease

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No25. Was case referred to medical examiner?
1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D36552

29d. Date signed (Month, Day, Year)

April 24, 1996

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

P. Talwar, M.D. 6121 Montrose Road, Rockville, MD. 20852

31. Date filed (Month, Day, Year)

MAY 08 1996

32. Registrar's Signature

John Anderson

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 15731

Certificate of Death

Reg. No.

| | | | | | |
|---|---|--|---|--------------------------------|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
WINTHROP F FARRELL, JR | | 2. Date of Death
Month MAY Day 6 Year 1996 | | 3. Time of Death
2:00 Am |
| | 4a. Facility Name (If not institution, give street and number)
PRINCE GEORGE'S HOSPITAL | | 4b. City, Town, or Location of Death
CHEVERLY | | 4c. County of Death
PRINCE GEORGE'S |
| Funeral
Director | 5. Social Security Number
022-38-2678 | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)
46 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. |
| | 8. Date of Birth (Month, Day, Year)
07-13-49 | | 9. Birthplace (State or Foreign Country)
BOSTON, MASS., | | |
| To Be Completed by Funeral Director | 10a. State
MD. | | 10b. County
PRINCE GEORGE'S | | 10c. City, Town or Location
ADELPHI |
| | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | |
| | 10e. Street and Number
9282 ADELPHI RD. #104 | | 10f. Zip Code
20783 | | 10g. Citizen of What Country?
U.S.A. |
| | 11. Marital Status
<input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |
| | 14. Race - American Indian, Black, White, etc.
Specify: WHITE | | | | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12TH College (1-4 or 5+) 6 | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
DEFENSE ANALYST | | 16b. Kind of Business/Industry
SCIENCE |
| | 17. Father's Name (First, Middle, Last)
WINTHROP F. FARRELL | | 18. Mother's Name (First, Middle, Maiden Surname)
MARIE L. TSIMIS | | |
| | 19a. Informant's Name/Relationship (Type, Print)
MARIE L. FARRELL | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
40 BROOKFIELD WINTHROP, MASSACHUSETTS 02152 | | |
| | 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
WINTHROP CEMETERY | | Date
05-11-96 |
| | 20c. Location - City or Town, State
WINTHROP, MASS. | | | | |
| 21. Signature of Funeral Service Licensed
<i>[Signature]</i> | | 22. Name and Address of Facility
E.M. DUDLEY 3200 RHODE ISLAND
FUNERAL HOME MOUNT RAINIER, MD. 20712 | | | |
| Physician
/Medical
Examiner | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

a. Hypertensive Cardiovascular Disease
Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of): | | | | Approximate Interval Between Onset and Death
years |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Arterio-venous malformation, large, Left Temporal lobe, s/p. hemorrhages (2 Times, 1980's) into brain; Seizure disorder. | | | | |
| To Be Completed by Physician/Medical Examiner | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | | |
| | 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | |
| To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner?
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input checked="" type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | |
| | 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation
2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined
3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day Year)
M
28b. Time of Injury
M
28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State) | | |
| To Be Completed by Physician/Medical Examiner | 29a. Certifier (Check only one)
1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | |
| | 29b. Signature and title of certifier
<i>[Signature]</i> MD | | 29c. License number
D25925 | | 29d. Date signed (Month, Day, Year)
May 8, 1996 |
| State Registrar | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
J. BERGER MD #208, 7720 WISCONSIN AVE, Bethesda, Md 20814 | | | | |
| | 31. Date filed (Month, Day, Year)
MAY 09 1996
32. Registrar's Signature
<i>[Signature]</i> | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

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96 15732

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--------------------------|--|--|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last)
JAMES E. GRIFFIN | | | | 2. DATE OF DEATH
MONTH DAY YEAR
MAY 11 1996 | | 3. TIME OF DEATH
11:45 M | |
| 4. SOCIAL SECURITY NUMBER
219-72-7035 | | 5. SEX
1 M 2 F | | 6. AGE (In yrs. last birthday)
50 YRS. | | 7. DATE OF BIRTH (Month, Day, Year)
NOV. 3 1946 | |
| 8. BIRTHPLACE (State or Foreign Country)
MARYLAND | | | | 9a. FACILITY NAME (If not institution, give street and number)
ANNE ARUNDEL MEDICAL CENTER | | 9b. CITY, TOWN OR LOCATION OF DEATH
ANNAPOLIS | |
| 9c. COUNTY OF DEATH
ANNE ARUNDEL | | | | 10a. STATE
MARYLAND | | 10b. COUNTY
ANNE ARUNDEL | |
| 10c. CITY, TOWN OR LOCATION
ANNAPOLIS | | | | 10d. INSIDE CITY LIMITS?
1 X YES 2 NO | | 10e. STREET AND NUMBER
1205 MADISON STREET APT. B3 | |
| 10f. ZIP CODE
21403 | | | | 10g. CITIZEN OF WHAT COUNTRY?
US | | 11. MARITAL STATUS
1 X Never Married 2 Married 3 Widowed 4 Divorced | |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 X NO
IF YES, GIVE WAR OR DATES | | | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 YES 2 X NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify:
BLACK | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12) 8th College (1-4 or 5+) 0 | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
CONSTRUCTION | | 16b. KIND OF BUSINESS/INDUSTRY
HEAD CONSTRUCTION CO. | |
| 17. FATHER'S NAME (First, Middle, Last)
JAMES A. GRIFFIN | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
HELEN WOOD | | | |
| 19a. INFORMANT'S NAME (Type/Print)
CATHERINE PARKER | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1216 BARBUD LANE ANNAPOLIS, MD. 21403 | | | |
| 20a. METHOD OF DISPOSITION
1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) | | | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
MOSES CEMETERY 5/16/96 | | 20c. LOCATION — City or Town, State
DRURY, MD. | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
<i>Larry H. Reese</i> | | | | 22. NAME AND ADDRESS OF FACILITY
WM. REESE & SONS MORTUARY, P.A.
821 WEST ST. ANNAPOLIS, MD. 21401 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>CANCER of Lung</i>
Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST
a. DUE TO (OR AS A CONSEQUENCE OF):
b. DUE TO (OR AS A CONSEQUENCE OF):
c. DUE TO (OR AS A CONSEQUENCE OF):
d. | | | | | | | Approximate Interval Between Onset and Death
3/96 |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
<i>RENAL FAILURE</i>
<i>DIABETIC NEPHROPATHY</i>
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | 24a. WAS AN AUTOPSY PERFORMED?
1 YES 2 NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 YES 2 NO | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
1 YES 2 X NO | | | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 Inpatient 2 ER/Outpatient 3 DOA OTHER: 4 Nursing Home 5 Residence 6 Other (Specify) | | | |
| 27. MANNER OF DEATH
1 X Natural 2 Accident 3 Suicide 4 Homicide 5 Pending Investigation 6 Could not be determined | | | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M | |
| 28c. INJURY AT WORK?
1 YES 2 NO | | | | 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. CERTIFIER (Check only one)
1 X CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
<i>Donald C. Roane, M.D.</i> | | | | 29c. LICENSE NUMBER
D 103 RF | | 29d. DATE SIGNED (Month, Day, Year)
5/12/96 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
Donald C. Roane, M.D. 1616 Forest Drive Annapolis | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
MAY 17 1996 | | | | 32. REGISTRAR'S SIGNATURE
<i>Julia Davidson-Randall</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 6876 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 96 15733

Certificate of Death

Reg. No.

| | | | | | | | | |
|--|---|--|--|---|--|---------------------------------|---|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
GEORGE WILLIAM GEHRKE | | | | 2. Date of Death
Month MAY Day 7 Year 1996 | | 3. Time of Death
5:00 AM | |
| | 4a. Facility Name (If not institution, give street and number)
9024 Lanham Severn Road | | | | 4b. City, Town, or Location of Death
Lanham | | 4c. County of Death
PRINCE GEORGE'S | |
| Funeral
Director | 5. Social Security Number
342-18-4298 | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday)
73 Yrs. | | 8. Date of Birth (Month, Day, Year)
October 21, 1922 | |
| | 9. Birthplace (State or Foreign Country)
Illinois | | 10a. State
Maryland | | 10b. County
Prince Georges | | 10c. City, Town or Location
Laurel | |
| To Be Completed by Funeral Director | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | 10e. Street and Number
9124 Briarchip Street | | 10f. Zip Code
20708 | |
| | 10g. Citizen of What Country?
U.S.A. | | | | 11. Marital Status
<input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
If Yes, Give Year or Date
Feb. 28, 1964 | |
| | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | | 14. Race - American Indian, Black, White, etc.
Specify:
Caucasian | | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (1-4or 5+) College (1-4or 5+) | |
| | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Military | | | | 16b. Kind of Business/Industry
U.S. Government | | | |
| | 17. Father's Name (First, Middle, Last)
Unknown | | | | 18. Mother's Name (First, Middle, Maiden Summa)
Unknown | | | |
| | 19a. Informant's Name/Relationship (Type, Print)
Myoung W. Paek-Son-in-Law | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
9124 Briarchip Street, Laurel, MD 20708 | | | |
| | 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Maryland Veterans Cemetery | | 20c. Location - City or Town, State
Cheltenham, MD | |
| | 21. Signature of Funeral Service Licensee
Plutanco Rendon | | | | 22. Name and Address of Facility
Rendon/Hale Funeral Home
9013 Annapolis Road, Lanham, MD 20706 | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. GENERALIZED ATHEROSCLEROTIC cardio-vascular Disease
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of): | | | | Approximate Interval Between Onset and Death
years | | | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I.
Chronic Obstructive Pulmonary Disease ; status post colectomy / colostomy / bladder carcinoma surgery | | | | 23b. Did tobacco use contribute to the cause of death?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | |
| 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No | | | | |
| 25. Was case referred to medical examiner?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide | | | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | | |
| 28c. Injury at Work?
<input type="checkbox"/> Yes <input type="checkbox"/> No | | | | 28d. Describe how Injury occurred | | | | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | |
| 29a. Certifier (Check only one)
<input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | 29b. Signature and title of certifier
[Signature] MD | | | | |
| 29c. License number
DZ5925 | | | | 29d. Date signed (Month, Day, Year)
May 7, 1996 | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
J. BERGER MD #205, 7720 Wisconsin Ave, BETHESDA, MD 20814 | | | | 31. Date filed (Month, Day, Year)
MAY 10 1996 | | | | |
| 32. Registrar's Signature
[Signature] | | | | State Registrar | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 15734

| | | | | | | | | |
|---|---|--|---|--|--|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
James Francis Gartland, Sr. | | | | 2. Date of Death
Month Day Year
May 11 1996 | | 3. Time of Death
9:04 P:M | |
| | 4a. Facility Name (If not institution, give street and number)
Physicians Memorial Hospital | | | | 4b. City, Town, or Location of Death
LaPlata | | 4c. County of Death
Charles | |
| Funeral
Director | 5. Social Security Number
049-12-8632 | | 6. Sex
1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 7. Age (In yrs. last birthday)
84 Yrs. | | 8. Date of Birth (Month, Day, Year)
Dec. 8, 1911 | |
| | 9. Birthplace (State or Foreign Country)
Connecticut | | 10a. State
Maryland | | 10b. County
Charles | | 10c. City, Town or Location
Waldorf | |
| To Be Completed by Funeral Director | 10d. Inside City Limits
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 10e. Street and Number
610 University Drive | | 10f. Zip Code
20602 | | 10g. Citizen of What Country?
USA | |
| | 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: White | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) College (1-4 or 5+) 5+ | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Judge | | 16b. Kind of Business/Industry
Law Enforcement | | | |
| | 17. Father's Name (First, Middle, Last)
Hugh J. Gartland | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Mary Doheny | | | |
| | 19a. Informant's Name/Relationship (Type, Print)
Michael S. Gartland | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
610 University Drive, Waldorf, MD 20602 | | | |
| | 20a. Method of Disposition
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Trinity Memorial Gardens | | 20c. Location - City or Town, State
Waldorf, MD | | | |
| | 21. Signature of Funeral Service Licensee
<i>Benjamin Matthews</i>
Benjamin Matthews M00658 | | 22. Name and Address of Facility
Huntt Funeral Home
P. O. box 156, Waldorf, MD 20604-0156 | | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | |
| | Immediate Cause (Final disease or condition resulting in death)
a. <u>Respiratory failure</u>
Due to (or as a consequence of):
b. <u>Adult Respiratory distress Syndrome</u>
Due to (or as a consequence of):
c. <u>Aspiration Pneumonia</u>
Due to (or as a consequence of):
d. | | | | | | | |
| | 23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
<u>Cardiac failure, Peripheral Vascular Disease.</u> | | | | | | | |
| 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown | | | | | | | | |
| 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | | | | |
| 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | | |
| 26. Place of Death (Check only one)
Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify) | | | | | | | | |
| 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | | | | | | | |
| 28a. Date of Injury (Month, Day, Year)
28b. Time of Injury
28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | | | | |
| 28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | |
| 29a. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | |
| 29b. Signature and title of certifier
<i>Girija Rath Consulting Physician</i>
29c. License number
D-12587
29d. Date signed (Month, Day, Year)
5-12-96 | | | | | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Girija Rath MD Cenna Medical Center 7-D Post Office Road Waldorf, Md. 20602 | | | | | | | | |
| 31. Date filed (Month, Day, Year)
MAY 17 1996
32. Registrar's Signature
<i>Julia Davidson-Randall</i> | | | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 15735

Certificate of Death

Reg. No.

| | | | | | | | | | | | | | | |
|--|---|--|---|--|--|--|---|--|--|--|--|--|---|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Irene Harried | | | | | | 2. Date of Death
Month Day Year
04 25 96 | | | 3. Time of Death
4:15 am | | | | |
| | 4a. Facility Name (If not institution, give street and number)
Pleasant Living Conv. Center | | | | | | 4b. City, Town, or Location of Death
Edgewater | | | 4c. County of Death
A.A. | | | | |
| Funeral
Director | 5. Social Security Number
212-22-4678 | | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday)
72 Yrs. | | If Under 1 Year
Months Days | | If Under 24 Hrs.
Hours Min. | | 8. Date of Birth (Month, Day, Year)
06/27/23 | | 9. Birthplace (State or Foreign Country)
MARYLAND | |
| | Usual Residence of Decedent | | | | | | | | | | | | | |
| To Be Completed by Funeral Director | 10a. State
MARYLAND | | 10b. County
ANNE ARUNDEL | | 10c. City, Town or Location
GALESVILLE | | | | | | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | |
| | 10e. Street and Number
4753 MUDDY CREEK ROAD | | | | | | 10f. Zip Code
20765 | | | 10g. Citizen of What Country?
US | | | | |
| | 11. Marital Status
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | | 14. Race - American Indian, Black, White, etc.
Specify: BLACK | | | | | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 5th College (1-4 or 5+) 0 | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
OYSTER SHUCKER | | | | 16b. Kind of Business/Industry
WOODFIELD OYSTER CO. | | | | | |
| | 17. Father's Name (First, Middle, Last)
GEORGE HICKS | | | | | | 18. Mother's Name (First, Middle, Maiden Surname)
DAISY | | | | | | | |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print)
MARY E. MACKELL (DAUGHTER) | | | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1907 E. COPELAND ST. ANNAPOLIS, MD. 21401 | | | | | | | |
| | 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
ANNAPOLIS MEM. GARDENS | | Date
5/3/96 | | 20c. Location - City or Town, State
ANNAPOLIS, MD. | | | | | |
| | 21. Signature of Funeral Service Licensee
Larry H. Reese | | | | | | 22. Name and Address of Facility
WM. REESE & SONS MORTUARY, P.A.
821 WEST ST. ANNAPOLIS, MD. 21401 | | | | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death) Renal failure
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

a. Due to (or as a consequence of):
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of): | | | | | | | | | | Approximate Interval Between Onset and Death
unknown | | | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
CVA | | | | | | | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | | |
| Medical Certification: To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | | | | | |
| | 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | | | | | |
| | | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| | 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier
[Signature] | | 29c. License number
D27569 | | 29d. Date signed (Month, Day, Year)
5/1/96 | | | | | | | |
| | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Allen Hettelman 1777 Risters town Rd #365 | | | | | | | | | | | | | |
| State Registrar | 31. Date filed (Month, Day, Year)
MAY 10 1996 | | | | 32. Registrar's Signature
[Signature] | | | | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 15736

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

CATHERINE ANTOINETTE HANNAN

2. Date of Death

Month Day Year
MAY 9, 1996

3. Time of Death

0345

4a. Facility Name (If not institution, give street and number)

CALVERT MEMORIAL HOSPITAL

4b. City, Town, or Location of Death

PRINCE FREDERICK

4c. County of Death

CALVERT

Funeral
Director

5. Social Security Number

202-26-6210

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

89 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
SEPT. 25, 1906

9. Birthplace (State or Foreign Country)

PA.

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

CALVERT

10c. City, Town or Location

DUNKIRK

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

10330 DEER TRAIL COURT

10f. Zip Code

20754

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.
Specify: WHITE

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

RET. BANK TELLER

16b. Kind of Business/Industry

MELLON BANK-PA.

17. Father's Name (First, Middle, Last)

LOUIS L. SCHWEINBERG

18. Mother's Name (First, Middle, Maiden Surname)

PHILOMENA SINGER

19a. Informant's Name/Relationship (Type, Print)

JOHN L. JOYCE

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

SAME AS #10

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

METROPOLITAN CREMATORY 5-11-96 ALEXANDRIA, VA.

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Michael B...

22. Name and Address of Facility

RAYMOND FUNERAL HOME
DUNKIRK, MARYLAND 20754

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Acute Respiratory Failure

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

1 day

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Severe Chronic Obstructive Pulmonary Disease

Due to (or as a consequence of):

years

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Ischemic Cardiomyopathy

Coronary Artery Disease

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending Investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, term, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Priscilla Cellar...

29c. License number

D41794

29d. Date signed (Month, Day, Year)

05-09-96

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

100 Hospital Rd, Prince Frederick, MD 20678

31. Date filed (Month, Day, Year)

MAY 10 1996

32. Registrar's Signature

Davidson-Randall

State
Registrar

Baltimore, Maryland 21215-0020

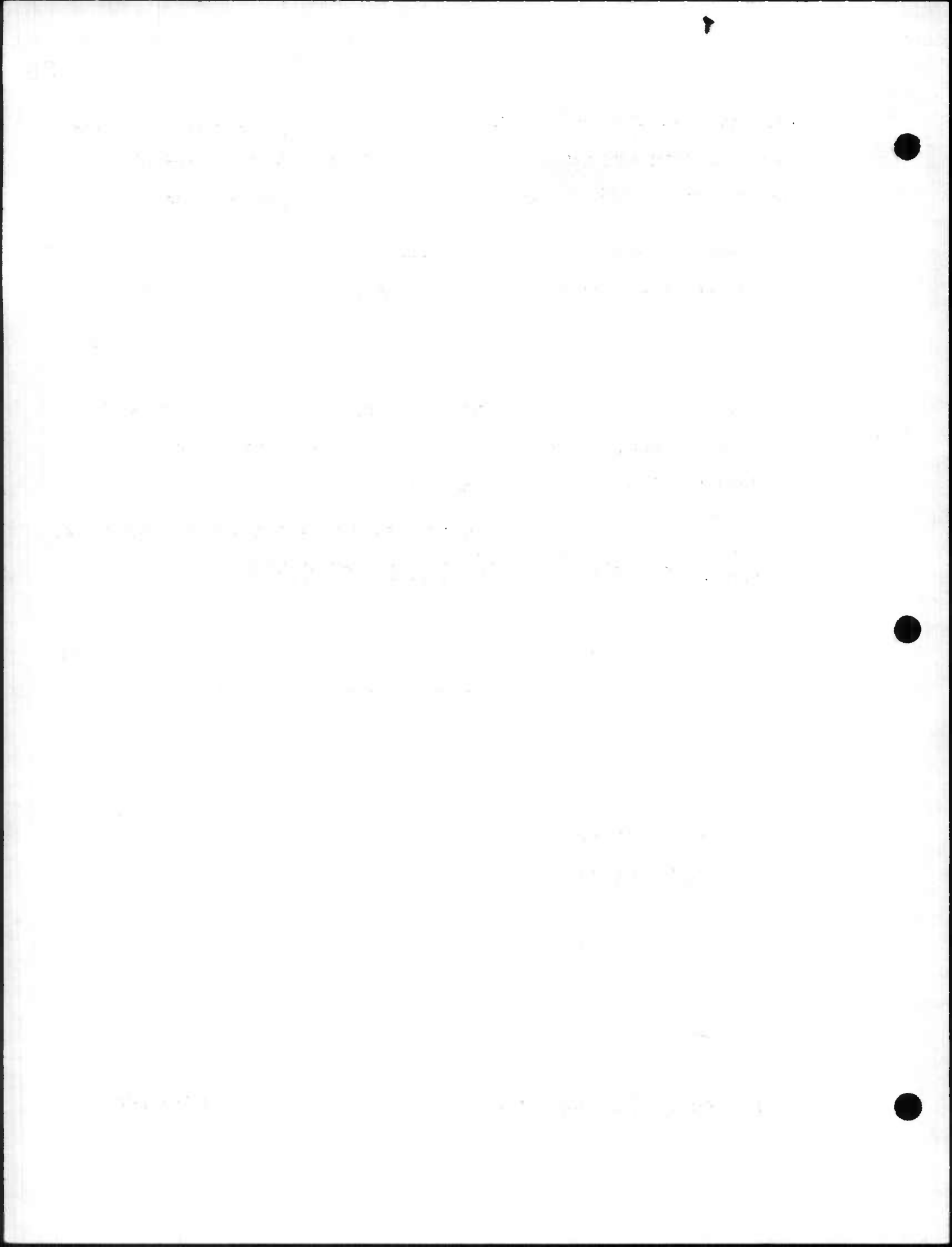
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 15737

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Catherine J. Hegarty

2. Date of Death

Month Day Year
April 29, 1996

3. Time of Death

5:55 PM

4a. Facility Name (If not institution, give street and number)

3409 Medina Lane

4b. City, Town, or Location of Death

Bowie

4c. County of Death

Prince George's

Funeral
Director

5. Social Security Number

209 26 1565

8. Sex

1 ☐ M ☒ F

7. Age (In yrs. last birthday)

61

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
May 3, 1934

9. Birthplace (State or Foreign Country)

Pennsylvania

Usual Residence of Decedent

10a. State

Maryland

10b. County

Prince George's

10c. City, Town or Location

Bowie

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

3409 Medina Lane

10f. Zip Code

20715

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.
Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Bookkeeper

16b. Kind of Business/Industry

Retail

17. Father's Name (First, Middle, Last)

Vincent M. Crowe

18. Mother's Name (First, Middle, Maiden Summa)

Nellie Duffy

19a. Informant's Name/Relationship (Type, Print)

Thomas F. Hegarty Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3409 Medina Lane Bowie Maryland 20715

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Maryland Veterans Cemetery 5/3/96 Crownsville Md.

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Robert E. Evans, Pres.

22. Name and Address of Facility

Robert E. Evans Funeral Home, P.A.
16000 Annapolis Rd. Bowie Md. 20715

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate
Interval Between
Onset and DeathImmediate Cause (Final
disease or condition
resulting in death)a. METASTATIC COLON CANCER
Due to (or as a consequence of):b. CACHEXIA
Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

CAUSE: COLDOVAGINAL FISTULA

IRON DEFICIENCY ANEMIA

METASTATIC DISEASE TO KIDNEY

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
Investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D46733

29d. Date signed (Month, Day, Year)

5/1/96

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Paula Lyons, MD Suite 118 14300 Gallant Fox Lane, Bowie, MD 20715

31. Date filed (Month, Day, Year)

MAY 10 1996

32. Registrar's Signature

Julia Anderson-Rodell

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 15738

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

VALENCIA HUTCHINSON

2. Date of Death

4-20-96

3. Time of Death

9:57 Am

4a. Facility Name (If not institution, give street and number)

ALLEGIS OF SOUTHERN MD.

4b. City, Town, or Location of Death

CLINTON, MD

4c. County of Death

P.G.

Funeral
Director

5. Social Security Number

577-68-4368

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

45

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

11-30-50

9. Birthplace (State or Foreign Country)

WASH., D.C.

Usual Residence of Decedent

10a. State

MD

10b. County

P.G.

10c. City, Town or Location

CLINTON MD

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

9211 STUART LANE

10f. Zip Code

20735

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: BLACK

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

SECRETARY

16b. Kind of Business/Industry

PRIVATE INDUSTRY

17. Father's Name (First, Middle, Last)

WILLIAM HARRISON SR.

18. Mother's Name (First, Middle, Maiden Surname)

IRENE BURTON

19a. Informant's Name/Relationship (Type, Print)

KATRINA HUTCHINSON

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4331 4TH ST. SE, #4 WASH., D.C. 20032

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

HARMONY MEMORIAL PARK

4/26/96

20c. Location - City or Town, State

LANDOVER, MD

21. Signature of Funeral Service Licensee

866

22. Name and Address of Facility

ROBERT G. MASON FUNERAL HOME, INC.

1661 GOOD HOPE ROAD S.E., WASH., D.C. 20020

23a. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a. Acquired Immuno def Syndrome

Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

months.

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. malnutrition

Due to (or as a consequence of):

c. Anemia

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation
6 ☐ Could not be determined

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

29c. License number

D46478

29d. Date signed (Month, Day, Year)

5-7-96

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Suresh A. Patel, M.D. 7501 Surratts Rd # 302 Clinton MD 20735

31. Date filed (Month, Day, Year)

MAY 07 1996

32. Registrar's Signature

John A. Anderson

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

2

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 15739

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Dwayne Merando Harris

2. Date of Death

Month
MayDay
8Year
1996

3. Time of Death

2151

4a. Facility Name (If not institution, give street and number)

The Kent & Queen Anne's Hospital Inc.

4b. City, Town, or Location of Death

Chestertown

4c. County of Death

Kent

Funeral
Director

5. Social Security Number

216-90-6542

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

34 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

Sept. 17, 1961

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Kent

10c. City, Town or Location

Chestertown

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

202 Roosevelt Dr.

10f. Zip Code

21620

10g. Citizen of What Country?

USA

11. Marital Status

1 ☒ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: Black

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12th

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working
life. DO NOT use retired)

Dietary Porter

16b. Kind of Business/Industry

Kent and Queen Annes
Hospital Inc.

17. Father's Name (First, Middle, Last)

Sylvester Harris, Jr.

18. Mother's Name (First, Middle, Maiden Surname)

Florence Murray

19a. Informant's Name/Relationship (Type, Print)

Florence Murray Harris

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

202 Roosevelt Dr, Chestertown, Md. 21620

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Jane's U.M. Church Cem.

Date

5/17/96

20c. Location - City or Town, State

Chestertown, Md.

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Bennie Smith Funeral Home
P.O. Box 1687, Easton, Md. 2160123a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)e. Massive bilateral pulmonary emboli
Due to (or as a consequence of):Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or Injury
that initiated events
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☒ Yes 2 ☐ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☒ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☒ Yes 2 ☐ No

Hospital:

1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
Investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury

(Month, Day, Year)

4 19 96

28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

playing basketball

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)

gym at school

28f. Location (Street and Number or Rural Route Number,
City or Town, State)

Brown St, Chestertown, MD

29a. Certifier
(Check only
one)1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D10001

29d. Date signed (Month, Day, Year)

5-9-96

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Harry Paul Ross, 516 Washington Ave, Chestertown, Md. 21620

31. Date filed (Month, Day, Year)

MAY 14 1996

32. Registrar's Signature

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

96 15740

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
Elizabeth Virginia Hopkins | | | | 2. DATE OF DEATH
MONTH May DAY 5 YEAR 1996 | | 3. TIME OF DEATH
4:30 AM | |
| 4. SOCIAL SECURITY NUMBER
217-14-8500 | | 5. SEX
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
73 YRS. | | 7. DATE OF BIRTH (Month, Day, Year)
Nov. 18 1922 | |
| 8. BIRTHPLACE (State or Foreign Country)
Maryland | | | | 9a. FACILITY NAME (If not institution, give street and number)
11444 Norris Twilley Road | | 9b. CITY, TOWN OR LOCATION OF DEATH
Mardela Springs | |
| 9c. COUNTY OF DEATH
Wicomico | | | | 10a. STATE
Maryland | | 10b. COUNTY
Wicomico | |
| 10c. CITY, TOWN OR LOCATION
Mardela Springs | | | | 10d. INSIDE CITY LIMITS?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 10e. STREET AND NUMBER
11444 Norris Twilley Road | |
| 10f. ZIP CODE
21837 | | | | 10g. CITIZEN OF WHAT COUNTRY?
U.S.A | | 11. MARITAL STATUS
1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify:
Black | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (1-4 or 5+) 3 | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
Domestic | | 16b. KIND OF BUSINESS/INDUSTRY
None | |
| 17. FATHER'S NAME (First, Middle, Last)
Reid Walker | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Lillian Adkins | | | |
| 19a. INFORMANT'S NAME (Type/Print)
Cecil Hopkins | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
11444 Norris Twilley Rd. Mardela Springs, Md. 21837 | | | |
| 20a. METHOD OF DISPOSITION
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
Zion Church Cemetery | | 20c. LOCATION — City or Town, State
Mardela Springs, Md. | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
Gladys B. Stewart | | | | 22. NAME AND ADDRESS OF FACILITY
Stewart Funeral Home
821 West Rd. Salisbury, Md. 21801 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Atherosclerosis of Large
DUE TO (OR AS A CONSEQUENCE OF):
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST
b. DUE TO (OR AS A CONSEQUENCE OF):
c. DUE TO (OR AS A CONSEQUENCE OF):
d.
Approximate Interval Between Onset and Death
~ 2 months from Diagnosis | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA
OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | |
| 27. MANNER OF DEATH
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide
5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M | |
| 28c. INJURY AT WORK?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | 28d. DESCRIBE HOW INJURY OCCURRED | | | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one)
1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
[Signature] | | | | 29c. LICENSE NUMBER
D45995 | | 29d. DATE SIGNED (Month, Day, Year)
5/7/96 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
560 Riverside Dr. Suite A-204 Salisbury MD 21804 | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
MAY 09 1996 | | | | 32. REGISTRAR'S SIGNATURE
[Signature] | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 6876 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

LINDA

L.

HAMLET

2. Date of Death

MAY 7, 1996

3. Time of Death

7:23PM

Funeral
Director

4a. Facility Name (If not institution, give street and number)

PENINSULA REGIONAL MEDICAL CENTER

4b. City, Town, or Location of Death

SALISBURY

4c. County of Death

WICOMICO

5. Social Security Number

219-36-5827

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

83

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

OCT. 23, 1912

9. Birthplace (State or Foreign Country)

DELAWARE

Usual Residence of Decedent

10a. State

MD.

10b. County

WICOMICO

10c. City, Town or Location

SALISBURY

10d. Inside City Limits

1 ☐ Yes ☒ No

10e. Street and Number

30423 WEST RUSTIC DRIVE

10f. Zip Code

21804

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

3

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

TEACHER

16b. Kind of Business/Industry

PUBLIC SCHOOL

17. Father's Name (First, Middle, Last)

CHARLES HENRY HARRISON ROGERS

18. Mother's Name (First, Middle, Maiden Surname)

CORA EDITH TRUITT

19a. Informant's Name/Relationship (Type, Print)

JOSEPH E. MOORE - ATTORNEY

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

P.O. BOX 739, OCEAN CITY, MARYLAND 21842

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

FRANKTOWN CEMETERY

Date

5/10

20c. Location - City or Town, State

FRANKTOWN, VIRGINIA

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

21804

BOUNDS FUNERAL HOME, 705 E. MAIN ST., SALISBURY, MD.

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

HEAD INJURY

a. ~~INTRACRANIAL HEMORRHAGE~~

Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☒ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☒ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

Hospital:

1 ☐ Inpatient2 ☒ Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

5/7/96

28b. Time of Injury

UNKNOWN

28c. Injury at Work?

1 ☐ Yes 2 ☒ No

28a. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

HOME

28d. Describe how injury occurred

SUBJECT FELL AT HOME

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30423 W. RUSTIC DRIVE

SALISBURY, WICOMICO CO., MD. 21801

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Dr. Clouette McKeel

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

MAY 8, 1996

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MARY SAUNDERS A. KOSOW 111 Penn Street, Baltimore, Maryland 21201

31. Date filed (Month, Day, Year)

MAY 09 1996

32. Registrar's Signature

John Davidson Radell

State
Registrar

Baltimore, Maryland 21215-0020

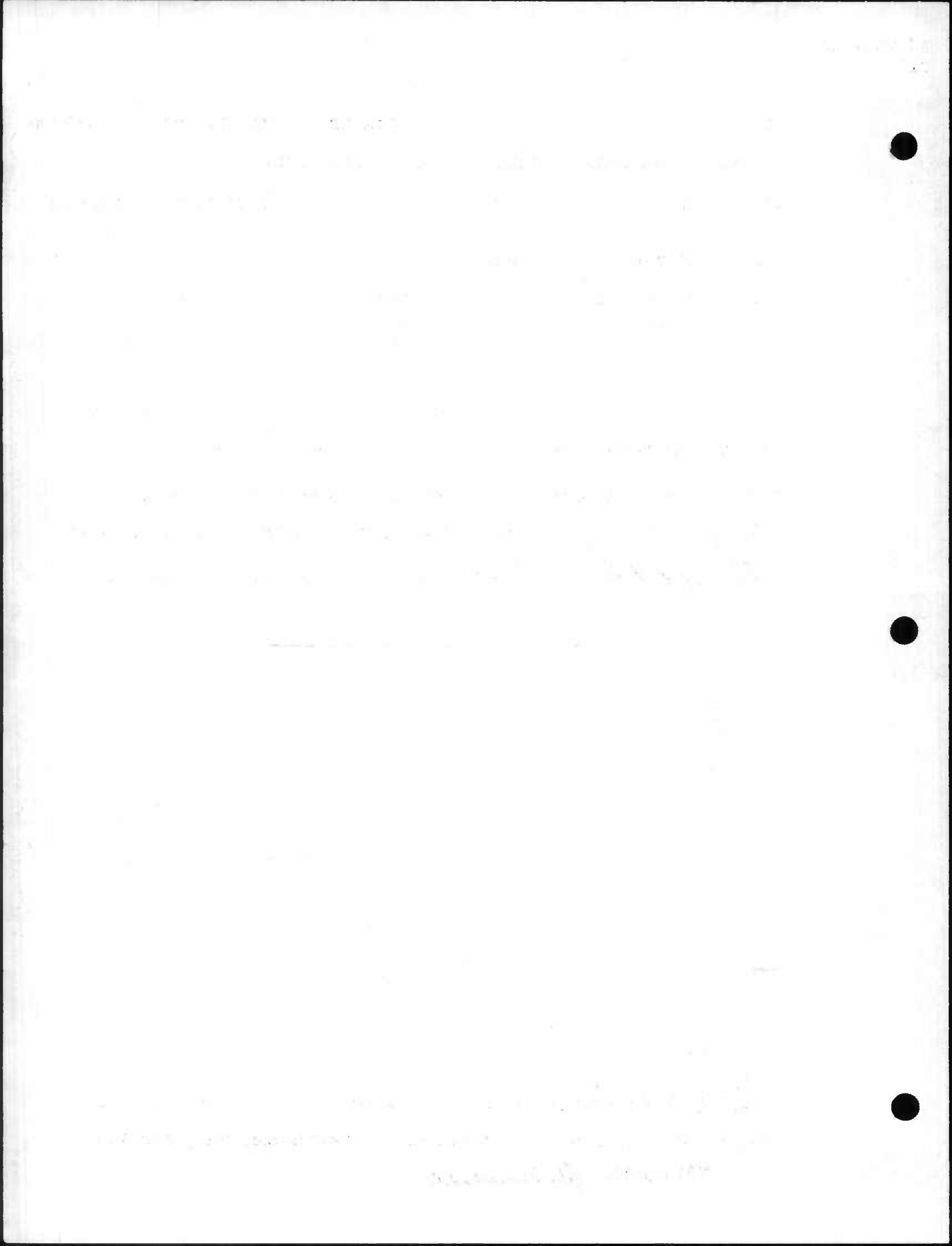
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 15742

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician
/Medical
ExaminerFuneral
Director

| | | | | | | |
|---|--|---|--|--|--|--|
| 1. Decedent's Name (First, Middle, Last)
DANIEL C. HOUSEHOLDER | | 2. Date of Death
Month MAY Day 12 Year 1996 | | 3. Time of Death
2:06 PM | | |
| 4a. Facility Name (If not institution, give street and number)
peninsula regional medical center | | 4b. City, Town, or Location of Death
SALISBURY | | 4c. County of Death
WICOMICO | | |
| 5. Social Security Number
164-58-4123 | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday)
35 Yrs. | | |
| 8. Date of Birth
(Month, Day, Year)
NOV. 11, 1960 | | 9. Birthplace (State or Foreign Country)
PENNSYLVANIA | | | | |
| Usual Residence of Decedent | | | | | | |
| 10a. State
MD | | 10b. County
WICOMICO | | 10c. City, Town or Location
SALISBURY | | |
| 10d. Inside City Limits
<input type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | |
| 10e. Street and Number
451 HASTINGS STREET | | 10f. Zip Code
21801 | | 10g. Citizen of What Country?
USA | | |
| 11. Marital Status
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | |
| 14. Race - American Indian, Black, White, etc.
Specify: WHITE | | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12
College (1-4 or 5+) College (1-4 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
MACHINIST | | |
| 16b. Kind of Business/Industry
MANUFACTURING | | 17. Father's Name (First, Middle, Last)
CHARLES E. HOUSEHOLDER | | 18. Mother's Name (First, Middle, Maiden Summa)
AUDREY L. SHEARER | | |
| 19a. Informant's Name/Relationship (Type, Print)
AUDREY L. SNOW | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
406 PARK AVENUE, SALISBURY, MD 21801 | | | | |
| 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
WICOMICO MEMORIAL PARK | | 20c. Location - City or Town, State
5/16 SALISBURY, MARYLAND | | |
| 21. Signature of Funeral Service Licensee
<i>Leonard D. Zeller</i> | | 22. Name and Address of Facility
ZELLER FUNERAL HOME, 1212 OLD OCEAN CITY ROAD, P. O. BOX 3171, SALISBURY, MD 21801 | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. Acute Narcotic and Ethanol Intoxication
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of): | | | | | | Approximate Interval Between Onset and Death
Unknown |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | |
| 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | | |
| 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | |
| 25. Was case referred to medical examiner?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | |
| 27. Manner of Death
<input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input checked="" type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year)
Found 3-11-96 | | 28b. Time of Injury
Found 9:20 A M | | |
| 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred
subject injected narcotic drug and alcohol | | | | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
Home | | 28f. Location (Street and Number or Rural Route Number, City or Town, State)
108 Prince St. Salisbury Md | | | | |
| 29a. Certifier (Check only one)
<input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier
<i>Dennis J. Chute MD</i> | | 29c. License number
O.C.M.E. | | |
| 29d. Date signed (Month, Day, Year)
MAY 13, 1996 | | | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Dennis J Chute MD 111 Penn Street, Baltimore, Maryland 21201 | | | | | | |
| 31. Date filed (Month, Day, Year)
MAY 16 1996 | | 32. Registrar's Signature
<i>John Davidson Randall</i> | | | | |

96 15743

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|---|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
LORETTA M JOHNSON | | | | 2. DATE OF DEATH
MONTH DAY YEAR
MAY 4 1996 | | 3. TIME OF DEATH
1525 M | |
| 4. SOCIAL SECURITY NUMBER
216-12-0283 | | 5. SEX
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
96 YRS. | | 7. DATE OF BIRTH (Month, Day, Year)
JULY 25 1899 | |
| 8. BIRTHPLACE (State or Foreign Country)
MARYLAND | | | | 9. COUNTY OF DEATH
MARYLAND | | | |
| 9a. FACILITY NAME (If not Institution, give street and number)
ANNE ARUNDEL MEDICAL CENTER | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
ANNAPOLIS | | 9c. COUNTY OF DEATH
ANNE ARUNDEL | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE
MARYLAND | | 10b. COUNTY
ANNE ARUNDEL | | 10c. CITY, TOWN OR LOCATION
BALTIMORE | | 10d. INSIDE CITY LIMITS?
1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER
617 LINNARD ST. | | | | 10f. ZIP CODE
21229 | | 10g. CITIZEN OF WHAT COUNTRY?
US | |
| 11. MARITAL STATUS
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify: BLACK | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12) 6th College (1-4 or 5+) 0 | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
DOMESTIC | | 16b. KIND OF BUSINESS/INDUSTRY
SOME ONE ELSE HOME | |
| 17. FATHER'S NAME (First, Middle, Last)
HARVEY ADAMS | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
MARY L. KEYS | | | |
| 19a. INFORMANT'S NAME (Type/Print)
MARY WELLS | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
13 COLLEGE CREEK TERRACE ANNAPOLIS, MD. 214401 | | | |
| 20a. METHOD OF DISPOSITION
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
ST. MARYS CHURCH CEMETERY 5/9/96 ANNAPOLIS, MD. | | 20c. LOCATION — City or Town, State | | 22. NAME AND ADDRESS OF FACILITY
WM. REESE & SONS MORTUARY, P.A.
821 WEST ST. ANNAPOLIS, MD. 21401 | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
<i>Larry H. Reese</i> | | | | 22. NAME AND ADDRESS OF FACILITY
WM. REESE & SONS MORTUARY, P.A.
821 WEST ST. ANNAPOLIS, MD. 21401 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Acute Cerebrovascular Accident
DUE TO (OR AS A CONSEQUENCE OF):
b. DUE TO (OR AS A CONSEQUENCE OF):
c. DUE TO (OR AS A CONSEQUENCE OF):
d. DUE TO (OR AS A CONSEQUENCE OF):
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | Approximate Interval Between Onset and Death
1 Day |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Previous Cerebrovascular Accident | | | | | | | 24a. WAS AN AUTOPSY PERFORMED?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/> | | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation
2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined
3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M | | 28c. INJURY AT WORK?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one)
1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
<i>William M. Attending Doctor</i> | | | | 29c. LICENSE NUMBER
D 21684 | | 29d. DATE SIGNED (Month, Day, Year)
5-4-96 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
CV. CYRIAC MD 1600 CRAWFORD, GLENBURN, MD 21061 | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
MAY 10 1996 | | | | 32. REGISTRAR'S SIGNATURE
<i>John Davidson-Randall</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

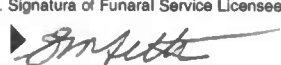
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 15744

Certificate of Death

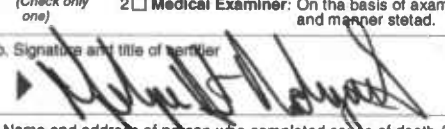
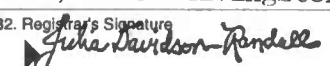
Reg. No.

| | | | | | | | | |
|--|--|--|--|--|---|--|--|---|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
KATIE JONES | | | | 2. Date of Death
Month MAY Day 11 Year 1996 | | 3. Time of Death
7:30pm | |
| | 4a. Facility Name (If not institution, give street and number)
Ft. Washington Hospital | | | | 4b. City, Town, or Location of Death
Ft. Washington | | 4c. County of Death
Prince George's | |
| Funeral
Director | 5. Social Security Number
466-40-1719 | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)
90 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth (Month, Day, Year)
08-27-05 | | 9. Birthplace (State or Foreign Country)
Texas |
| | Usual Residence of Decedent | | | | | | | |
| 10a. State
MD | | 10b. County
Prince George's | | 10c. City, Town or Location
Ft. Washington | | | 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 10e. Street and Number
12003 Bion Drive | | | | 10f. Zip Code
20744 | | 10g. Citizen of What Country?
United States | | |
| 11. Marital Status
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc.
Specify: Black | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 6 College (1-4or 5+) 0 | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Housewife | | | 16b. Kind of Business/Industry
Home | |
| 17. Father's Name (First, Middle, Last)
James Unknown Childress | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Sally Unknown Smith | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
Dotson Burns, Jr. | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
12003 Bion Drive, Ft. Washington, MD 20744 | | | | |
| 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Cedar Hill Cemetery | | | 20c. Date
5/21/96 | | 20d. Location - City or Town, State
Ft. Worth, TX | |
| 21. Signature of Funeral Service Licensee
 | | | | 22. Name and Address of Facility
FELTON FUNERAL SERVICES
P.O. Box 1351, Forestville, MD 20747 | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

a. SEPSIS-
Due to (or as a consequence of):
b. Complete large Bowel obstruction
Due to (or as a consequence of):
c. METASTATIC Cancer to liver
Due to (or as a consequence of):
d. RECTO-SIGMOID CARCINOMA | | | | | | | | Approximate Interval Between Onset and Death

5/6/96
+
5/12/96 |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | |
| | | | | | | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicida <input type="checkbox"/> Homicida <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input type="checkbox"/> No | | 28d. Describe how injury occurred |
| | | 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier
 | | | | | | |
| | | 29c. License number
D35174 MD | | 29d. Date signed (Month, Day, Year)
05/12/96 | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Felipe A. Rodriguez, M.D., 11701 Livingston Rd., Suite 203, Ft. Washington, MD 20744 | | | | | | | | |
| 31. Date filed (Month, Day, Year)
MAY 17 1996 | | 32. Registrar's Signature
 | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

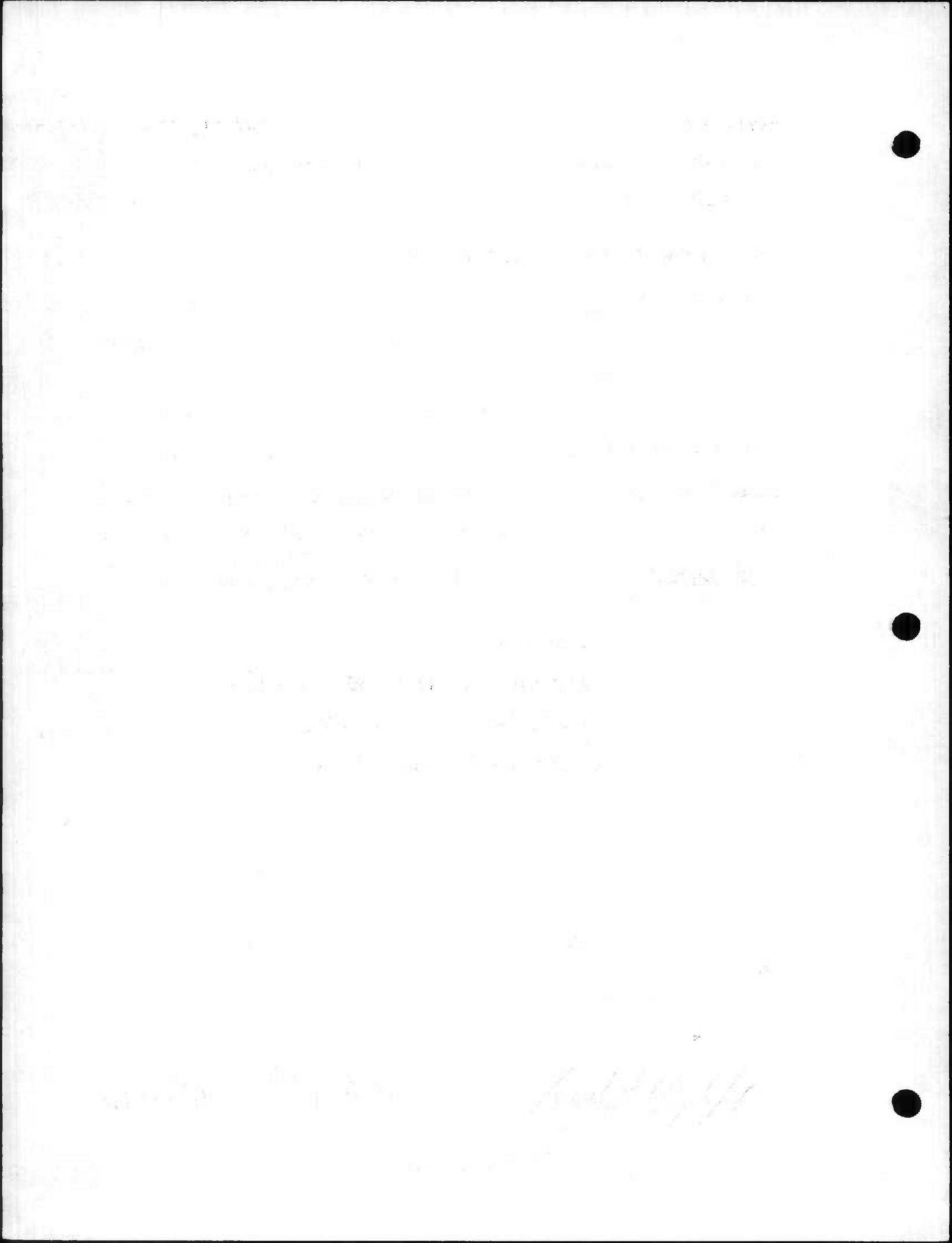
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar



1 - STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|--|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last)
DORIS JEFFERSON | | | | 2. DATE OF DEATH
MONTH 5 DAY 2 YEAR 1996 | | 3. TIME OF DEATH
9:49 A.M. | |
| 4. SOCIAL SECURITY NUMBER
227-30-8238 | | 5. SEX
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
68 73 YRS. | | 7. DATE OF BIRTH
2/15/28 | |
| 9a. FACILITY NAME (If not institution, give street and number)
MANOR CARE NSG HOME | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
LARGO, MARYLAND | | 9c. COUNTY OF DEATH
PRINCE GEORGES | |
| 10a. STATE
Md. | | | | 10b. COUNTY
Prince Georges | | 10c. CITY, TOWN OR LOCATION
Temple Hills | |
| 10d. INSIDE CITY LIMITS?
<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | | | 10e. STREET AND NUMBER
3513 Orme Drive | | | |
| 10f. ZIP CODE
20748 | | | | 10g. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | |
| 11. MARITAL STATUS
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify: Black | |
| 15. DECEDENT'S EDUCATION
(Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (1-4 or 5+) 4 | | 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.)
Crypt Analyst | | 16b. KIND OF BUSINESS/INDUSTRY
Private Industry | | | |
| 17. FATHER'S NAME (First, Middle, Last)
Richard Byrd | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Elizabeth Buckner | | | |
| 19a. INFORMANT'S NAME (Type/Print)
John R. Jefferson | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
3513 Orme Dr., Temple Hills, Md., 20748 | | | |
| 20a. METHOD OF DISPOSITION
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
Forest Lawn Cemetery | | 20c. LOCATION — City or Town, State
Richmond, Va. | | 20d. DATE
5-7-96 | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
W. G. Jefferson | | | | 22. NAME AND ADDRESS OF FACILITY
Frazier Funeral Home
389 Rhode Island Av., NW, Washington, D.C. | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Carcinoma of Pancreas with bony metastasis and spinal cord compression
Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. metastasis and spinal cord compression
c. DUE TO (OR AS A CONSEQUENCE OF):
d. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | Approximate interval Between Onset and Death
Several years |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | 24a. WAS AN AUTOPSY PERFORMED?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | | | | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA
OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M | | 28c. INJURY AT WORK?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | 29a. CERTIFIER (Check only one)
<input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
M. Amin MD | | | | 29c. LICENSE NUMBER
D-18895 | | 29d. DATE SIGNED (Month, Day, Year)
May 02, 1996 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
MOBARAK KARIM, 7610 CARROLL AVENUE, TAKOMA PARK, MARYLAND 20912 | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
MAY 06 1996 | | | | 32. REGISTRAR'S SIGNATURE
J. A. Davidson-Randall | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 15746

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

GLORIA JEAN JONES

2. Date of Death

Month Day Year
APRIL 25, 1996

3. Time of Death

10:41 AM

4a. Facility Name (If not institution, give street and number)

National Institute of Health

4b. City, Town, or Location of Death

Bethesda

4c. County of Death

Montgomery

Funeral
Director

5. Social Security Number

002-26-4448

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

61 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Feb. 27, 1935

9. Birthplace (State or Foreign Country)

Virginia

Usual Residence of Decedent

10a. State

Va.

10b. County

Prince William

10c. City, Town or Location

Manassas

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

8137 Bethlehem Road

10f. Zip Code

22110

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married

3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

4

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Guidance Counselor

16b. Kind of Business/Industry

Private School

17. Father's Name (First, Middle, Last)

Commodore N. Bennett

18. Mother's Name (First, Middle, Maiden Surname)

Burnley Muriel Washington

19a. Informant's Name/Relationship (Type, Print)

Antoine Douglas

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

8137 Bethlehem Rd., Manassas, Virginia

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State

4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Stonewall Jackson Mem. Gar.

Date

5-4-96

20c. Location - City or Town, State

Manassas, Va.

21. Signature of Funeral Service Licensee

W.G. Jeffers

22. Name and Address of Facility

Frazier's Funeral Home

389 Rhode Island Av., NW, Washington, D.C., 20001

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Acute Respiratory Distress

Due to (or as a consequence of):

b. Non Hodgkins Lymphoma

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

10 Days

20 years

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☒ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☒ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending Investigation

2 ☐ Accident

3 ☐ Suicide

4 ☐ Homicide

6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Pamela M. Klein M.D.

29c. License number

CALIF 6077710

29d. Date signed (Month, Day, Year)

4/26/96

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

PAMELA M. KLEIN, M.D.

9000 ROCKVILLE PIKE, BETHESDA, MARYLAND 20892

31. Date filed (Month, Day, Year)

MAY 06 1996

32. Registrar's Signature

John H. ...

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 202-343-0000.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Division of Vital Records, P.O. Box 68760,

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 15747

Certificate of Death

Reg. No.

| | | | | | | | | |
|---|--|--|--|---|--|--|--|---|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
<i>James Johnson</i> | | | | 2. Date of Death
Month <i>4</i> Day <i>2</i> Year <i>2000</i> | | 3. Time of Death
<i>6:50 am</i> | |
| | 4a. Facility Name (If not institution, give street and number)
<i>Holy Cross Hospital</i> | | | | 4b. City, Town, or Location of Death
<i>Takoma Park</i> | | 4c. County of Death
<i>Montgomery</i> | |
| Funeral
Director | 5. Social Security Number
<i>578-16-7783</i> | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)
<i>83</i> Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth (Month, Day, Year)
<i>June 7, 1912</i> | 9. Birthplace (State or Foreign Country)
<i>Washington, D.C.</i> |
| | Usual Residence of Decedent | | | | 10c. City, Town or Location
<i>Washington, D.C.</i> | | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | |
| 10e. State | | 10b. County | | 10f. Zip Code
<i>20002</i> | | 10g. Citizen of What Country?
<i>U.S.A.</i> | | |
| 10e. Street and Number
<i>200 Rhode Island Av., N.E.</i> | | 11. Marital Status
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: <i>Black</i> |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) <i>12</i> | | College (1-4 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
<i>Gardner</i> | | 16b. Kind of Business/Industry
<i>U.S. Government</i> | | |
| 17. Father's Name (First, Middle, Last)
<i>Edward Johnson</i> | | | | 18. Mother's Name (First, Middle, Maiden Surname)
<i>Cleopatra Smith</i> | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
<i>Eveline Davis Sister-in-Law</i> | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
<i>200 Rhode Island Av., NE, Washington, D.C., 20002</i> | | | | |
| 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
<i>Maryland National Cem.</i> | | 20c. Location - City or Town, State
<i>Laurel, Md.</i> | | 20d. Date
<i>5/7/96</i> | | |
| 21. Signature of Funeral Service Licensee
<i>W. J. Jeffers</i> | | | | 22. Name and Address of Facility
<i>Frazier's Funeral Home
389 Rhode Island Av., NW, Washington, D.C., 20001</i> | | | | |
| 23a. Part I. Enter the disease, or complications, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | | |
| Immediate Cause (Final disease or condition resulting in death) | | a. <i>Congestive Right heart</i>
Due to (or as a consequence of):
b. <i>Right heart ulcerations & cellulitis</i>
Due to (or as a consequence of):
c. <i>Dist Vascular Varies</i>
Due to (or as a consequence of):
d. <i>acute Arteriosclerotic Peripheral Vascular disease</i> | | | | | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
<i>CHF, QSOVD</i> | | | | | | | | |
| 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | | | | | | | |
| 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year)
<i>N/A</i> | | 28b. Time of Injury
<i>M</i> | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| | | 28d. Describe how injury occurred | | 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)
<i>N/A</i> | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier
<i>DBPth MD</i> | | | | | | |
| | | 29c. License number
<i>D17228</i> | | 29d. Date signed (Month, Day, Year)
<i>4/27/96</i> | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
<i>60. Patricia M. 9241 Coleville Rd Silver Spring, Md 20910</i> | | | | | | | | |
| 31. Date filed (Month, Day, Year)
<i>MAY 09 1996</i> | | 32. Registrar's Signature
<i>John Shuckard</i> | | | | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

62

1. The first part of the report deals with the general situation of the country and the progress of the work during the year. It is a summary of the work done and the results obtained. It is a general statement of the work done and the results obtained.

2. The second part of the report deals with the details of the work done during the year. It is a detailed statement of the work done and the results obtained. It is a detailed statement of the work done and the results obtained.

3. The third part of the report deals with the conclusions drawn from the work done during the year. It is a summary of the conclusions drawn from the work done and the results obtained. It is a summary of the conclusions drawn from the work done and the results obtained.

96 15748

FOR
STATE
REGISTRAR Item: 19b, per F.H. G-738 re

8/6/96 STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH REG. NO.

| | | | | | |
|---|--|---|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last)
CHRISTOPHER DAVON JIMASON | | 2. DATE OF DEATH
MONTH MAY DAY 3 YEAR 1996 | | 3. TIME OF DEATH
8:35 AM | |
| 4. SOCIAL SECURITY NUMBER
213-37-0482 | | 5. SEX
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
3 YRS. | |
| 7. DATE OF BIRTH
(Month, Day, Year)
08-22-92 | | 8. BIRTHPLACE (State or Foreign Country)
Washington DC | | | |
| 9a. FACILITY NAME (If not institution, give street and number)
Laurel Regional Hospital | | 9b. CITY, TOWN OR LOCATION OF DEATH
Laurel | | 9c. COUNTY OF DEATH
PRINCE GEORGES | |
| RESIDENCE OF DECEDENT | | | | | |
| 10a. STATE
MD | | 10b. COUNTY
Prince George's | | 10c. CITY, TOWN OR LOCATION
Mitchellville | |
| 10d. INSIDE CITY LIMITS?
<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | | | | |
| 10e. STREET AND NUMBER
9604 Bald Hill Road | | 10f. ZIP CODE
20721 | | 10g. CITIZEN OF WHAT COUNTRY?
USA | |
| 11. MARITAL STATUS
<input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | |
| 14. RACE — American Indian, Black, White, etc.
Specify: Black | | | | | |
| 15. DECEDENT'S EDUCATION
(Specify only highest grade completed)
Elementary/Secondary (0-12) N/A
College (1-4 or 5+) N/A | | 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.)
N/A | | 16b. KIND OF BUSINESS/INDUSTRY
N/A | |
| 17. FATHER'S NAME (First, Middle, Last)
David Wayne Thompson | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Tasha Catrice Jimason | | | |
| 19a. INFORMANT'S NAME (Type/Print)
Tasha Jimason/Mother | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
9604 Bald Hill Rd, Mitchellville, MD 20721 | | | |
| 20a. METHOD OF DISPOSITION
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
Harmony Memorial Park 5/11 Landover, MD | | 20c. LOCATION — City or Town, State | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
<i>Kimberly C Buscetric</i> | | 22. NAME AND ADDRESS OF FACILITY
J. B. Jenkins Funeral Home
7474 Landover Rd, Landover, MD 20785 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
IMMEDIATE CAUSE (Final disease or condition resulting in death) → SEPSIS
DUE TO (OR AS A CONSEQUENCE OF):
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. DUE TO (OR AS A CONSEQUENCE OF):
c. DUE TO (OR AS A CONSEQUENCE OF):
d. DUE TO (OR AS A CONSEQUENCE OF): | | | | | Approximate Interval Between Onset and Death
hours |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
CEREBRAL PALSY, MICROSCOPHALY | | | | | 24a. WAS AN AUTOPSY PERFORMED?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
<input type="checkbox"/> YES <input type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA
OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | |
| 27. MANNER OF DEATH
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation
<input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined
<input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M | |
| | | 28c. INJURY AT WORK?
<input type="checkbox"/> YES <input type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | |
| | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. CERTIFIER (Check only one)
<input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
<i>J. Berger MD</i> | | 29c. LICENSE NUMBER
025925 | | 29d. DATE SIGNED (Month, Day, Year)
May 3, 1996 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
J. BERGER MD #205, 7720 Wisconsin Ave, Bethesda Md 20814 | | | | | |
| 31. DATE FILED (Month, Day, Year)
MAY 09 1996 | | 32. REGISTRAR'S SIGNATURE
<i>John A. ...</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

THE UNIVERSITY OF CHICAGO

PHYSICS DEPARTMENT

RESEARCH REPORT

1963

BY

JOHN H. SCHUBERT


Submitted to the Department of Physics

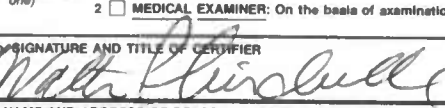
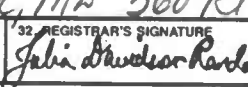
1963

96 15749

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|---|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
ETHEL V. JONES | | | | 2. DATE OF DEATH
MONTH MAY DAY 4 YEAR 1996 | | 3. TIME OF DEATH
11:55 P M | |
| 4. SOCIAL SECURITY NUMBER
213-42-0198 | | 5. SEX
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
84 YRS. | | 7. DATE OF BIRTH (Month, Day, Year)
AUG. 1, 1911 | |
| 8. BIRTHPLACE (State or Foreign Country)
MARYLAND | | | | 9a. FACILITY NAME (If not institution, give street and number)
10835 CATHELL ROAD | | 9b. CITY, TOWN OR LOCATION OF DEATH
BERLIN | |
| 9c. COUNTY OF DEATH
WORCESTER | | | | 10a. STATE
MARYLAND | | 10b. COUNTY
WORCESTER | |
| 10c. CITY, TOWN OR LOCATION
BERLIN | | | | 10d. INSIDE CITY LIMITS?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 10e. STREET AND NUMBER
10835 CATHELL ROAD | |
| 10f. ZIP CODE
21811 | | 10g. CITIZEN OF WHAT COUNTRY?
USA | | 11. MARITAL STATUS
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | |
| 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify:
WHITE | | 15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12) 11 College (1-4 or 5+) 11 | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
HOMEMAKER | |
| 16b. KIND OF BUSINESS/INDUSTRY
OWN HOME | | 17. FATHER'S NAME (First, Middle, Last)
HARRY HUDSON | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
NANCY DAISEY | | 19a. INFORMANT'S NAME (Type/Print)
PEGGY J. BISHOP | |
| 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
P.O. BOX 42, SHOWELL, MARYLAND 21862 | | 20a. METHOD OF DISPOSITION
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
BISHOPVILLE CEMETERY 5/8/96 | | 20c. LOCATION — City or Town, State
BISHOPVILLE, MARYLAND | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
 | | | | 22. NAME AND ADDRESS OF FACILITY
HASTINGS FUNERAL HOME, SELBYVILLE, DELAWARE | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>Cardiopulmonary arrest</u>
Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST { b. <u>metastatic colon cancer</u>
c.
d.
Approximate Interval Between Onset and Death
4/4/94
1/14/94 | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | 24a. WAS AN AUTOPSY PERFORMED?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation
2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined
3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide 4 <input type="checkbox"/> | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 28c. INJURY AT WORK?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | 29a. CERTIFIER (Check only one)
1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
 | | 29c. LICENSE NUMBER
D31887 | | 29d. DATE SIGNED (Month, Day, Year)
5/7/96 | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
Walter P. Lischick, MD 560 Riverside Dr Suite A206 Salisbury, MD 21801 | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
MAY 07 1996 | | | | 32. REGISTRAR'S SIGNATURE
 | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

96 15750

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
Arthur Korsunsky | | | | 2. DATE OF DEATH
MONTH DAY YEAR
May 9 1996 | | 3. TIME OF DEATH
5:35AM | |
| 4. SOCIAL SECURITY NUMBER
212-03-7461 | | 5. SEX
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
82 YRS. | | 7. DATE OF BIRTH (Month, Day, Year)
Feb 13 1914 | |
| 8. BIRTHPLACE (State or Foreign Country)
Maryland | | | | 9. FACILITY NAME (If not institution, give street and number)
Anne Arundel Medical Center | | | |
| 10. CITY, TOWN OR LOCATION OF DEATH
Annapolis | | | | 11. COUNTY OF DEATH
Anne Arundel | | | |
| 12. STATE
MD | | 13. COUNTY
Anne Arundel | | 14. CITY, TOWN OR LOCATION
Annapolis | | 15. INSIDE CITY LIMITS?
<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | |
| 16. STREET AND NUMBER
169 King George Street | | | | 17. ZIP CODE
21401 | | 18. CITIZEN OF WHAT COUNTRY?
United States | |
| 19. MARITAL STATUS
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 20. WAS DECEDENT EVER IN U.S. ARMED FORCES?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 21. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 22. RACE — American Indian, Black, White, etc.
Specify: White | |
| 23. DECEDENT'S EDUCATION
(Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (1-4 or 5+) College | | 24. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.)
Retailer | | 25. KIND OF BUSINESS/INDUSTRY
Smoke Shop | | | |
| 26. FATHER'S NAME (First, Middle, Last)
Joseph Korsunsky | | | | 27. MOTHER'S NAME (First, Middle, Maiden Surname)
Bella Pushkin | | | |
| 28. INFORMANT'S NAME (Type/Print)
Francis J. Keller/Nephew | | | | 29. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
110 Magnolia Lane Annapolis, Maryland 21403 | | | |
| 30. METHOD OF DISPOSITION
<input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 31. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
Ft. Lincoln Crematory 5/10/96 | | 32. DATE
5/10/96 | | 33. LOCATION — City or Town, State
Brentwood, Maryland | |
| 34. SIGNATURE OF FUNERAL SERVICE LICENSEE
<i>[Signature]</i> | | | | 35. NAME AND ADDRESS OF FACILITY
John M. Taylor Funeral Home
147 Duke Of Gloucester St. Annapolis, MD | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. cerebrovascular accident | | | | | | | |
| DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| b. hypertension | | | | | | | |
| DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| c. | | | | | | | |
| DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| d. | | | | | | | |
| Approximately Interval Between Onset and Death
11 days
years | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
diabetes mellitus
atrial fibrillation
coronary artery disease | | | | | | | |
| 36. WAS AN AUTOPSY PERFORMED?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 37. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | | |
| 38. WAS CASE REFERRED TO MEDICAL EXAMINER?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 39. PLACE OF DEATH (Check only one)
HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA
OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 40. MANNER OF DEATH
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | 41. DATE OF INJURY (Month, Day, Year) | | 42. TIME OF INJURY
M | | 43. INJURY AT WORK?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 44. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 45. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 46. CERTIFIER (Check only one)
<input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 47. SIGNATURE AND TITLE OF CERTIFIER
<i>[Signature]</i> | | | | 48. LICENSE NUMBER
045297 | | 49. DATE SIGNED (Month, Day, Year)
5-9-96 | |
| 50. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
Elaine M Arata MD 600 Ridgely Ave Suite 131 Annapolis MD 21401 | | | | | | | |
| 51. DATE FILED (Month, Day, Year)
MAY 10 1996 | | | | 52. REGISTRAR'S SIGNATURE
<i>[Signature]</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

11120

1000 1000 1000

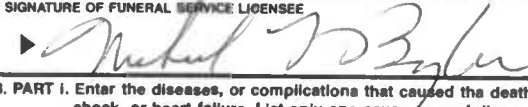


1000 1000 1000

1000 1000 1000

96 15751

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
SETH IRELAND KRUSA | | | | 2. DATE OF DEATH
MONTH MAY DAY 8 YEAR 96 | | 3. TIME OF DEATH
7:31 PM | |
| 4. SOCIAL SECURITY NUMBER
219 21 9267 | | 5. SEX
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
24 YRS. | | 7. DATE OF BIRTH (Month, Day, Year)
Feb. 5, 1972 | |
| 8. BIRTHPLACE (State or Foreign Country)
D.C. | | | | 9a. FACILITY NAME (If not institution, give street and number)
WASHINGTON ADVENTIST HOSPITAL | | 9b. CITY, TOWN OR LOCATION OF DEATH
TAKOMA PARK | |
| 9c. COUNTY OF DEATH
MONTGOMERY | | | | 10a. STATE
MD. | | 10b. COUNTY
MONTGOMERY | |
| 10c. CITY, TOWN OR LOCATION
SILVER SPRING | | | | 10d. INSIDE CITY LIMITS?
<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | 10e. STREET AND NUMBER
720 RITCHIE AVE. | |
| 10f. ZIP CODE
20910 | | | | 10g. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 11. MARITAL STATUS
<input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify: WHITE | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12) TWO College (13-16 or 17+) | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
CLERK | | 16b. KIND OF BUSINESS/INDUSTRY
DEPT. OF TRANSPORTATION | |
| 17. FATHER'S NAME (First, Middle, Last)
CHRISTOPHER E. KRUSA | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
LORRINE IRELAND | | | |
| 19a. INFORMANT'S NAME (Type/Print)
CHRISTOPHER KRUSA | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
SAME AS 10e | | | |
| 20a. METHOD OF DISPOSITION
<input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
METROPOLITAN CREMATORY MAY 18, 1996 Alexandria, Va | | 20c. LOCATION — City or Town, State | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
 | | | | 22. NAME AND ADDRESS OF FACILITY
TAKOMA FUNERAL HOME INC 254 CARROLL ST N.W. WASHINGTON, D.C. 20012 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
IMMEDIATE CAUSE (Final disease or condition resulting in death) → Hangings
a. DUE TO (OR AS A CONSEQUENCE OF):
b. DUE TO (OR AS A CONSEQUENCE OF):
c. DUE TO (OR AS A CONSEQUENCE OF):
d. DUE TO (OR AS A CONSEQUENCE OF):
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | |
| 27. MANNER OF DEATH
<input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation
<input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined
<input type="checkbox"/> Homicide | | | | 28a. DATE OF INJURY (Month, Day, Year)
MAY 8 96 | | 28b. TIME OF INJURY
6:05 PM | |
| 28c. INJURY AT WORK?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | 28d. DESCRIBE HOW INJURY OCCURED
Hangings | | | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
Home | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
720 RITCHIE AVE SS. | | | |
| 29a. CERTIFIER (Check only one)
<input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
 | | | | 29c. LICENSE NUMBER
208546 | | 29d. DATE SIGNED (Month, Day, Year)
MAY 8 96 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
John Tauber 8218 WILSON AVE Bethesda MD | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
MAY 10 1996 | | | | 32. REGISTRAR'S SIGNATURE
 | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 15752

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Irene Pamela Krueger

2. Date of Death

Month

Day

Year

May 5

1996

3. Time of Death

7:00 P.M.

Funeral
Director

4a. Facility Name (If not institution, give street and number)

12908 Cheswood Lane

4b. City, Town, or Location of Death

Bowie

4c. County of Death

Prince George's

5. Social Security Number

179 24 9144

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

64

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)

Feb. 4, 1932

9. Birthplace (State or Foreign Country)

Pennsylvania

Usual Residence of Decedent

10a. State

Maryland

10b. County

Prince George's

10c. City, Town or Location

Bowie

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

12908 Cheswood Lane

10f. Zip Code

20715

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married2 ☐ Married3 ☐ Widowed4 ☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give Year or Dates:

Korean

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No

Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

Collegiate (14 or 5+)

5+

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Registered

Nurse

16b. Kind of Business/Industry

Health Care

17. Father's Name (First, Middle, Last)

Thomas Zapotsky

18. Mother's Name (First, Middle, Maiden Surname)

Justyna Lazar

19a. Informant's Name/Relationship (Type, Print)

Karl B. Krueger Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

712 Quiet Pond Court Odenton Maryland 21113

20a. Method of Disposition

1 ☐ Burial2 ☒ Cremation3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Metropolitan Crematory 5/8/96

Data

20c. Location - City or Town, State

Alexandria Virginia

21. Signature of Funeral Service Licensee

Robert E. Evans, Pres

22. Name and Address of Facility

Robert E. Evans Funeral Home, P.A.
16000 Annapolis Rd. Bowie Md. 20715

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Progressive respiratory insufficiency

Due to (or as a consequence of):

weeks

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Adenocarcinoma of left lung

Due to (or as a consequence of):

months

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Chronic obstructive pulmonary disease

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☒ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28e. Location (Street and Number or Rural Route Number, City or Town, State)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Norton Elson MD

29c. License number

D20362

29d. Date signed (Month, Day, Year)

May 7, 1996

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Norton Elson 6525 Belcrest Road Hyattsville MD 20782

31. Date filed (Month, Day, Year)

MAY 08 1996

32. Registrar's Signature

John H. H. H. H.

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 15753

Physician
/Medical
ExaminerFuneral
Director

| | | | | | | | |
|--|--|---|--|--|--|--|--|
| 1. Decedent's Name (First, Middle, Last)
EDWARD KUSMAN | | | | 2. Date of Death
Month Day Year
MAY 13, 1996 | | 3. Time of Death
12:05 PM | |
| 4a. Facility Name (If not institution, give street and number)
PHYSICIANS MEMORIAL HOSPITAL | | | | 4b. City, Town, or Location of Death
LaPlata | | 4c. County of Death
CHARLES | |
| 5. Social Security Number
134-38-1228 | | 8. Sex
1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 7. Age (In yrs. last birthday)
48 Yrs. | | 8. Date of Birth (Month, Day, Year)
Jul. 27, 1947 | |
| 9. Birthplace (State or Foreign Country)
New York | | 10a. State
Maryland | | 10b. County
Charles | | 10c. City, Town or Location
Waldorf | |
| 10d. Inside City Limits
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 10e. Street and Number
6401 Bear Court | | 10f. Zip Code
20603 | | 10g. Citizen of What Country?
USA | |
| 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: White | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12)
12 | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Truck Driver | | 16b. Kind of Business/Industry
Transportation | | | |
| 17. Father's Name (First, Middle, Last)
Edward Kusman | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Roseanna Darcey | | | |
| 19a. Informant's Name/Relationship (Type, Print)
Dolores Kusman | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
6401 Bear Court, Waldorf, MD 20603 | | | |
| 20a. Method of Disposition
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Resurrection Cemetery | | Date
5-17 | | 20c. Location - City or Town, State
Clinton, MD | |
| 21. Signature of Funeral Service Licensee
Benjamin Matthews M00658 | | | | 22. Name and Address of Facility
Huntt Funeral Home, Inc.
P. O. box 156, Waldorf, MD 20604 | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

e. CARDIOMYOPATHY Due to (or as a consequence of):
b. CHRONIC OBSTRUCTIVE PULMONARY DISEASE Due to (or as a consequence of):
c. DISEASE Due to (or as a consequence of):
d.

Approximate Interval Between Onset and Death
4 YEARS
FEW YEARS | | | | | | | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
DIABETES MELLITUS | | | | | | | 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |
| 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | | | |
| 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accidental 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide
5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of injury (Month, Day, Year) | | 28b. Time of injury
M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| 28d. Describe how injury occurred | | 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | |
| 29b. Signature and title of certifier
[Signature] | | | | 29c. License number
321173 | | 29d. Date signed (Month, Day, Year)
5/13/96 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
NIAAN. P. SHARMA, 104 PENBROOKE SQ WALDORF MD. | | | | | | | |
| 31. Date filed (Month, Day, Year)
MAY 17 1996 | | | | 32. Registrar's Signature
Julia Davidson-Randall | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 23b-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 15754

Physician
/Medical
ExaminerFuneral
Director

1. Decedent's Name (First, Middle, Last)

HAYNES LOCKLEAR

2. Date of Death

Month Day Year
APRIL 26, 1996

3. Time of Death

10:37pm

4a. Facility Name (If not institution, give street and number)

Prince Georges General Hospital

4b. City, Town, or Location of Death

cheverly

4c. County of Death

Prince Georges

5. Social Security Number

240 26 2772

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

81 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

May 8, 1914

9. Birthplace (State or Foreign Country)

North Carolina

Usual Residence of Decedent

10a. State

md.

10b. County

Prince Georges

10c. City, Town or Location

cheverly

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10a. Street and Number

2900 mercy Lane

10f. Zip Code

20785

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: white

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
12

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

car Salesman

16b. Kind of Business/Industry

Auto

17. Father's Name (First, Middle, Last)

unknown

18. Mother's Name (First, Middle, Maiden Surname)

unknown

19a. Informant's Name/Relationship (Type, Print)

Rosemary Madden

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

5012 Rhode Island Ave, Hyattsville, Md. 20781

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Glenwood Cemetery

Date

May 10, 1996

20c. Location - City or Town, State

Washington, D.C.

21. Signature of Funeral Service Licensee

Michael Z. Byler

22. Name and Address of Facility

TAKOMA FUNERAL HOME 254 Carroll St. NW Washington, D.C. 20012

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Sepsis Syndrome

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

1 day

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Cellulitis of Gastrostomy Site

Due to (or as a consequence of):

3 days

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Dementia. possible metabolic

turn to ribs

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Michael Z. Byler Attorney

29c. License number

220577

29d. Date signed (Month, Day, Year)

4/27/96

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Don Yablonsky 7404 Executive Place #502, Bethesda, MD 20814

31. Date filed (Month, Day, Year)

MAY 10 1996

32. Registrar's Signature

John A. ...

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

State of Maryland / Department of Health and Mental Hygiene 96 15755
Certificate of Death Reg. No.

Reg. No.

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 15756

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

James Henry LAWRENCE, II

2. Date of Death

May 6, 1996

3. Time of Death

4:30P

4a. Facility Name (If not institution, give street and number)

DOCTOR'S HOSPITAL

4b. City, Town, or Location of Death

LANHAM

4c. County of Death

PRINCE GEORGE'S

Funeral
Director

5. Social Security Number

245-40-7012

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

63 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

JUNE 1, 1932

9. Birthplace (State or Foreign Country)

GASTON COUNTY, NC

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

PRINCE GEORGE'S

10c. City, Town or Location

BOWIE

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

4408 WOODGATE WAY

10f. Zip Code

20720

10g. Citizen of What Country?

USA

11. Marital Status

☐ Never Married ☒ Married
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces? ☒ Yes ☐ NoIf Yes, Give
Year or Dates: 10/18/51
04/25/5213. Was Decedent of Hispanic Origin? (Specify Yes or No
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)☐ Yes ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: BLACK

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

5+

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

FORENSIC CHEMIST

16b. Kind of Business/Industry

GOVT. (DEA)

17. Father's Name (First, Middle, Last)

JAMES ANDERSON LAWRENCE

18. Mother's Name (First, Middle, Maiden Surname)

CARRIE GLENN

19a. Informant's Name/Relationship (Type, Print)

JANICE C. LAWRENCE/ WIFE

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4408 WOODGATE WAY BOWIE, MARYLAND 20720

20a. Method of Disposition

☐ Burial ☐ Cremation ☒ Removal from State
☐ Donation ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

GASTON MEMORIAL PARK

Date

5/13/96

20c. Location - City or Town, State

GASTONIA, NC

21. Signature of Funeral Service Licensee

Shawana A. Braxton

22. Name and Address of Facility

MARSHALL'S FUNERAL HOME
4308 SUTLAND RD SUTLAND, MD 2074623a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Approximate
Interval Between
Onset and DeathImmediate Cause (Final
disease or condition
resulting in death)a. CARDIAC ARREST
Due to (or as a consequence of):

MINUTES

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or Injury
that initiated events
resulting in death) Lastb. OBSTRUCTIVE AND RESTRICTIVE LUNG DISEASE MONTHS
Due to (or as a consequence of):c. METASTATIC ESOPHAGEAL CARCINOMA MONTHS
Due to (or as a consequence of):

d. ESOPHAGEAL CARCINOMA 3 YEARS

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

SEVERE PERIPHERAL VENOUS INCOMPETANCE

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown24a. Was an autopsy
performed?☐ Yes ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?☐ Yes ☐ No25. Was case referred to medical
examiner?☐ Yes ☒ No

Hospital:

☒ Inpatient☐ ER/Outpatient☐ DOA

26. Place of Death (Check only one)

Other:

☐ Nursing Home ☐ Residence ☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending
Investigation
☐ Accident ☐ Could not be
determined
☐ Suicide ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of
Injury

M

28c. Injury at
Work?☐ Yes ☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

29c. License number

D31069

29d. Date signed (Month, Day, Year)

May 7, 1996

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. George H. Bone 9602F M.L. King, Jr Highway Lanham, MD 20706

31. Date filed (Month, Day, Year)

MAY 09 1996

32. Registrar's Signature

John H. H. H. H.

State
Registrar

Baltimore, Maryland 21215-0020

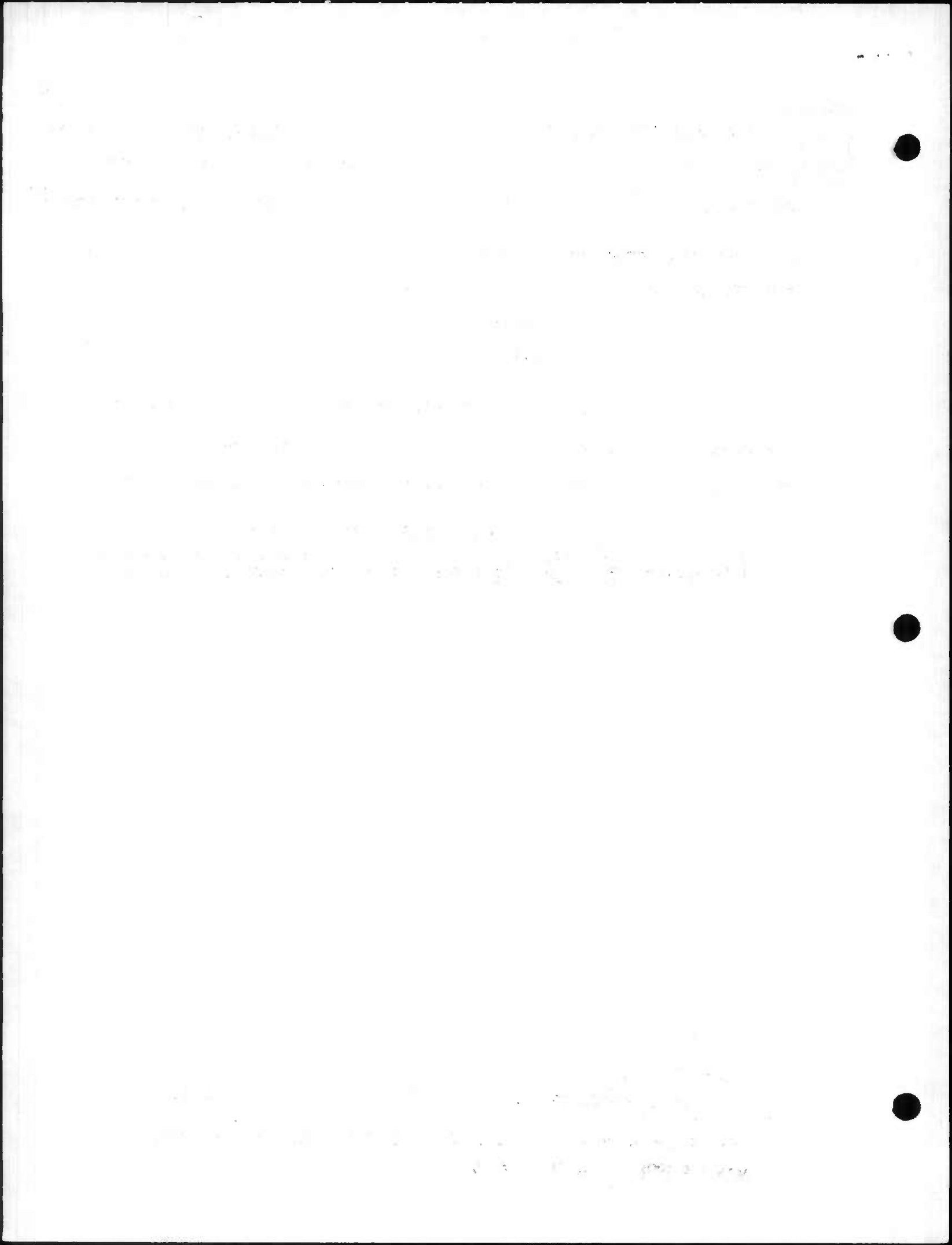
Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.Physician
/Medical
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

10



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 15757

Certificate of Death

Reg. No.

| | | | | | | | | |
|--|--|---|--|--|--|---|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
<u>Carter, R. Lincoln</u> | | | | 2. Date of Death
Month <u>May</u> Day <u>7</u> Year <u>1996</u> | | 3. Time of Death
<u>3:55 AM</u> | |
| | 4a. Facility Name (If not institution, give street and number)
<u>SUBURBAN HOSPITAL</u> | | | | 4b. City, Town, or Location of Death
<u>Bethesda</u> | | 4c. County of Death
<u>Montgomery</u> | |
| Funeral
Director | 5. Social Security Number
<u>144-12-1096</u> | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)
<u>75</u> Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 6. Date of Birth (Month, Day, Year)
<u>Sept. 2, 1920</u> | |
| | Usual Residence of Decedent | | 9. Birthplace (State or Foreign Country)
<u>West Virginia</u> | | | | | |
| To Be Completed by Funeral Director | 10a. State
<u>Maryland</u> | | 10b. County
<u>Montgomery</u> | | 10c. City, Town or Location
<u>Silver Spring</u> | | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | |
| | 10e. Street and Number
<u>404 Thayer Avenue</u> | | | | 10f. Zip Code
<u>20910</u> | | 10g. Citizen of What Country?
<u>United States</u> | |
| | 11. Marital Status
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <u>3/12/43</u>
If Yes, Give Year or Dates: <u>12/30/45</u> | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: <u>Black</u> | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) <u>1</u> College (1-4or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
<u>Retired Business Owner</u> | | 16b. Kind of Business/Industry
<u>Self Employed</u> | | | |
| | 17. Father's Name (First, Middle, Last)
<u>Rufus Hayes Lincoln</u> | | | | 18. Mother's Name (First, Middle, Maiden Surname)
<u>Frances Jackson</u> | | | |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print)
<u>Ernestine B. Lincoln - Wife</u> | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
<u>404 Thayer Avenue, Silver Spring, MD 20910</u> | | | |
| | 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
<u>Maryland Veterans Cemetery</u> | | 20c. Location - City or Town, State
<u>5/10/96 Cheltenham, MD</u> | | | |
| | 21. Signature of Funeral Service Licensee
<u>John T. Stewart III</u> | | | | 22. Name and Address of Facility
<u>STEWART FUNERAL HOME, Inc.</u>
<u>4001 Benning Road, N.E., Washington, D.C.</u> | | | |
| | 23a. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
<u>BLADDER CANCER</u> | | | | | | | Approximate Interval Between Onset and Death
<u>8 YEARS</u> |
| | 23b. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
<u>VENOUS THROMBOSIS, PULMONARY EMBOLISM,</u>
<u>DIABETES MELLITUS, CONGESTIVE HEART</u>
<u>FAILURE, HYPERTENSION</u> | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
<u>VENOUS THROMBOSIS, PULMONARY EMBOLISM,</u>
<u>DIABETES MELLITUS, CONGESTIVE HEART</u>
<u>FAILURE, HYPERTENSION</u> | | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | |
| 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation
<input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined
<input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier
<u>Daniel Rosenthal</u> | | 29c. License number
<u>204766</u> | | 29d. Date signed (Month, Day, Year)
<u>5/7/96</u> | | |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)
<u>10400 CONNECTICUT AVE 606 KENSINGTON, MD 20895</u> | | | | | | | | |
| 31. Date filed (Month, Day, Year)
<u>MAY 09 1996</u> | | 32. Registrar's Signature
<u>Julia Shuckler-Randall</u> | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

State
Registrar

[Faint, illegible handwritten notes]

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

96 15758

Reg. No.

| | | | | | | | | |
|--|---|--|---|---|--|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Malon A. LEWIS | | | 2. Date of Death
Month May Day 4 Year 1996 | | 3. Time of Death
2:10 p.m. | | |
| | 4a. Facility Name (If not institution, give street and number)
Doctors Community Hospital of P.G. County | | | 4b. City, Town, or Location of Death
Lanham | | 4c. County of Death
Prince George's | | |
| Funeral
Director | 5. Social Security Number
243-44-2214 | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday)
69 Yrs. | | 8. Date of Birth (Month, Day, Year)
Sept. 11, 1926 | |
| | 9. Birthplace (State or Foreign Country)
North Carolina | | | | | | | |
| To Be Completed by Funeral Director | Usual Residence of Decedent | | | | | | | |
| | 10a. State
Maryland | | 10b. County
Prince Georges | | 10c. City, Town or Location
Landover Hills | | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | |
| | 10e. Street and Number
6729 Darby Road | | | 10f. Zip Code
20784-2423 | | 10g. Citizen of What Country?
United States | | |
| | 11. Marital Status
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No 2/7/45
If Yes, Give Year or Dates: 7/9/46 | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify:
African American | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Retired Federal Employee | | 16b. Kind of Business/Industry
Dept. of Defense | | |
| | 17. Father's Name (First, Middle, Last)
Jacob Lewis | | | 18. Mother's Name (First, Middle, Maiden Surname)
Otia Allen | | | | |
| | 19a. Informant's Name/Relationship (Type, Print)
Lula Gertrude Lewis | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
6729 Darby Road, Hyattsville, MD 20784 | | | | |
| | 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Allen Family Cemetery | | Date
5/9/96 | | 20c. Location - City or Town, State
Fuquay Varina, N.C. | |
| | 21. Signature of Funeral Service Licensee
John T. Stewart III | | | 22. Name and Address of Facility
Stewart Funeral Home, Inc.
4001 Benning Road, N.E., Washington, D. C. | | | | |
| | 23. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | |
| Physician
/Medical
Examiner | Immediate Cause (Final disease or condition resulting in death) | | | a. Respiratory Failure
Due to (or as a consequence of): | | Approximate Interval Between Onset and Death
one month | | |
| | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last | | | b. Chronic Obstructive lung Disease
Due to (or as a consequence of): | | Several years | | |
| | | | | c.
Due to (or as a consequence of): | | | | |
| | | | | d.
Due to (or as a consequence of): | | | | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | |
| | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | | | |
| | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No | | | | |
| | 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | 26. Place of Death (Check only one)
Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | |
| | 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input type="checkbox"/> No | |
| | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | 28d. Describe how injury occurred | | | | |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | |
| 29a. Certifier
(Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | |
| 29b. Signature and title of certifier
MD | | | 29c. License number
D-18895 | | 29d. Date signed (Month, Day, Year)
May 04, 1996 | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
MOBARAK KARIM, 7610 CARROLL AVENUE, TAKOMA PARK, MD 20912 | | | | | | | | |
| 31. Date filed (Month, Day, Year)
MAY 09 1996 | | | 32. Registrar's Signature
John H. ... | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 15759

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Raymond Allen Larmore

2. Date of Death

Month Day Year
May 7 1996

3. Time of Death

3:30 PM

4a. Facility Name (If not institution, give street and number)

Salisbury Center; Genesis ElderCare

4b. City, Town, or Location of Death

Salisbury, Md.

4c. County of Death

Wicomico

Funeral
Director

5. Social Security Number

431-48-0388

6. Sex

XXM 2 F

7. Age (In yrs. last birthday)

82

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
July 7, 1913

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Wicomico

10c. City, Town or Location

Salisbury

10d. Inside City Limits

1 Yes 2 No

10e. Street and Number

31890 Old Ocean City Rd.

10f. Zip Code

21804

10g. Citizen of What Country?

USA

11. Marital Status

1 Never Married 2 Married
3 Widowed 4 Divorced

12. Was Decedent Ever In U.S.

Armed Forces?

1 Yes 2 No

If Yes, Give Year or Dates: WW II

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 Yes 2 No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
8College (1-4or 5+)
0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Cabinet Maker

16b. Kind of Business/Industry

Carpentry

17. Father's Name (First, Middle, Last)

William H. Larmore

18. Mother's Name (First, Middle, Maiden Surname)

Elizabeth E. Bounds

19a. Informant's Name/Relationship (Type, Print)

William H. Larmore Jr./brother

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

31890 Old Ocean City Rd., Salisbury, MD 21804

20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Wicomico Memorial Park

Date

5/11/96

20c. Location - City or Town, State

Salisbury, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Holloway Funeral Home

501 Snow Hill Rd., Salisbury, MD 21804

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Congestive Heart Failure
Due to (or as a consequence of):

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate interval Between Onset and Death

1 week

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Multiple Insect Bites

Recent Pneumonia - Complete Blood

23b. Did tobacco use contribute to the cause of death?

1 Yes 2 No 3 Probably 4 Unknown

24a. Was an autopsy performed?

1 Yes 2 No

24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No

25. Was case referred to medical examiner?
1 Yes 2 No

Hospital:

1 Inpatient 2 ER/Outpatient 3 DOA

26. Place of Death (Check only one)

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

27. Manner of Death

1 Natural 2 Accident 3 Suicide 4 Homicide
5 Pending investigation 6 Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 Yes 2 No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D-39813

29d. Date signed (Month, Day, Year)

5/8/96

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MICHAEL ATKINS, M.D., 1104 HEALTHWAY DR., SALISBURY, MD. 21804

31. Date filed (Month, Day, Year)

MAY 9 1996

32. Registrar's Signature

John Davidson Randall

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

THE UNIVERSITY OF CHICAGO
DIVISION OF THE PHYSICAL SCIENCES
DEPARTMENT OF PHYSICS



THE UNIVERSITY OF CHICAGO
DIVISION OF THE PHYSICAL SCIENCES
DEPARTMENT OF PHYSICS

THE UNIVERSITY OF CHICAGO
DIVISION OF THE PHYSICAL SCIENCES
DEPARTMENT OF PHYSICS

96 15760

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|---|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
Ervil Phillip Matthews | | | | 2. DATE OF DEATH
MONTH 04 DAY 29 YEAR 96 | | 3. TIME OF DEATH
8:10 AM | |
| 4. SOCIAL SECURITY NUMBER
214-28-9942 | | 5. SEX
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
66 YRS. | | 7. DATE OF BIRTH (Month, Day, Year)
12-23-29 | |
| 9a. FACILITY NAME (If not institution, give street and number)
WILTON MANOR NURSING CENTER | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
CLINTON | | 9c. COUNTY OF DEATH
PRINCE GEORGE | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE
MAARYLAND | | 10b. COUNTY
PRINCE GEORGE | | 10c. CITY, TOWN OR LOCATION
UPPER MARLBORO | | 10d. INSIDE CITY LIMITS?
<input type="checkbox"/> YES <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER
15228 MARLBORO PIKE | | | | 10f. ZIP CODE
20772 | | 10g. CITIZEN OF WHAT COUNTRY?
US | |
| 11. MARITAL STATUS
<input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify: BLACK | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12) 12th College (1-4 or 5+) 0 | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
CAATERER | | 16b. KIND OF BUSINESS/INDUSTRY
SELF EMPLOYED | |
| 17. FATHER'S NAME (First, Middle, Last)
ERVIL P. MATTHEWS | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
MARY I. JONES | | | |
| 19a. INFORMANT'S NAME (Type/Print)
CHARLES L. MATTHEWS (NEPHEW) | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
15228 MARLBORO PIKE UPPER MARLBORO, MD. 20772 | | | |
| 20a. METHOD OF DISPOSITION
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
RESURRECTION CEMETERY | | 20c. LOCATION — City or Town, State
5/6/96 CLINTON, MD. | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
Harry M. Reese | | | | 22. NAME AND ADDRESS OF FACILITY
WM. REESE & SONS MORTUARY, P.A.
821 WEST ST. ANNAPOLIS, MD. 21401 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | | a. Cardio Pulmonary arrest. | | | | Approximate Interval Between Onset and Death
None | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | b. Encephalopathy and L. | | | | year | |
| | | c. Diabetic melis | | | | years | |
| | | d. arterio sclerosis | | | | years | |
| | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
per cutaneous enteleptic gastroscopy | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M | | 28c. INJURY AT WORK?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| | | 28d. DESCRIBE HOW INJURY OCCURED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. CERTIFIER (Check only one)
<input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
K. D. m. | | | | 29c. LICENSE NUMBER
D25640 | | 29d. DATE SIGNED (Month, Day, Year)
4/30/96 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
WILTON MANOR NURSING CENTER CLINTON, MD. | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
MAY 13 1996 | | | | 32. REGISTRAR'S SIGNATURE
Julia Davidson-Randall | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 15761

| | | | | | | | | | |
|---|--|---|--|--|---|--|---|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
<i>Thelma McDonald</i> | | | | | 2. Date of Death
Month <i>5</i> Day <i>11</i> Year <i>1996</i> | | 3. Time of Death
<i>3:15 AM</i> | |
| | 4a. Facility Name (If not institution, give street and number)
<i>Anne Arundel Medical Center</i> | | | | | 4b. City, Town, or Location of Death
<i>Annapolis</i> | | 4c. County of Death
<i>Anne Arundel</i> | |
| Funeral
Director | 5. Social Security Number
<i>372-01-7379</i> | | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)
<i>81 Yrs.</i> | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth (Month, Day, Year)
<i>January 9, 1915</i> | | 9. Birthplace (State or Foreign Country)
<i>Michigan</i> |
| | Usual Residence of Decedent | | 10a. State
<i>Maryland</i> | | 10b. County
<i>Anne Arundel</i> | | 10c. City, Town or Location
<i>Annapolis</i> | | 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| 10e. Street and Number
<i>3109 River Crescent Drive</i> | | 10f. Zip Code
<i>21401</i> | | 10g. Citizen of What Country?
<i>United States</i> | | | | | |
| 11. Marital Status
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: <i>White</i> | | | |
| 15. Decedent's Education (Specify only highest grade completed)
<i>Elementary/Secondary (0-12)</i> | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
<i>Homemaker</i> | | 16b. Kind of Business/Industry
<i>Domestic</i> | | | | | |
| 17. Father's Name (First, Middle, Last)
<i>Clarence MacDonald</i> | | | | | 18. Mother's Name (First, Middle, Maiden Summa)
<i>Mable Stuckey</i> | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
<i>Elizabeth J. Riggs</i> | | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
<i>10008 Branch View Court, Silver Spring, Md. 20903</i> | | | | |
| 20a. Method of Disposition
<input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
<i>Fort Lincoln Crematory 5-13</i> | | 20c. Location - City or Town, State
<i>Brentwood, Maryland</i> | | | | | |
| 21. Signature of Funeral Service Licensee
<i>[Signature]</i> | | | | | 22. Name and Address of Facility
<i>John M. Taylor Funeral Home, Inc. 147 Duke of Gloucester St., Annapolis, 21401</i> | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. <i>COPD</i>
Due to (or as a consequence of):
b. <i>Tobacco Use</i>
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | | | Approximate Interval Between Onset and Death |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | |
| | | | | | | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
<i>M</i> | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | |
| | | 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28t. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier
<i>[Signature]</i> | | 29c. License number
<i>1731602</i> | | 29d. Date signed (Month, Day, Year)
<i>5/11/96</i> | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
<i>George Cavanaugh MD 1655 Cotton Blvd. Suite 103 Cotton, MD 21114</i> | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
<i>MAY 13 1996</i> | | 32. Registrar's Signature
<i>[Signature]</i> | | | | | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 96 15762
Certificate of Death

Reg. No.

Physician
/Medical
ExaminerFuneral
Director

1. Decedent's Name (First, Middle, Last)

Charles S Matthews

2. Date of Death
Month Day Year

May 9, 1996

3. Time of Death

10:45 PM

4a. Facility Name (If not institution, give street and number)

Southern Maryland Hospital

4b. City, Town, or Location of Death

Clinton

4c. County of Death

Prince Georges

5. Social Security Number

218-24-3044

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

65 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth
(Month, Day, Year)

DEC. 27 1930

9. Birthplace (State or Foreign Country)

D.C.

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

PRINCE GEORGE

10c. City, Town or Location

UPPER MARLBORO

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

15228 MARLBORO PIKE

10f. Zip Code

20772

10g. Citizen of What Country?

US

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No
If Yes, Give Year or Dates: 1951-53

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: BLACK

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12th

College (1-4 or 5+)

0

16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)

MECHANIC

16b. Kind of Business/Industry

EASTERN WASTE

17. Father's Name (First, Middle, Last)

ERVIL P. MATTHEWS

18. Mother's Name (First, Middle, Maiden Surname)

MARY I. JONES

19a. Informant's Name/Relationship (Type, Print)

LILLIAN M. MATTHEWS (WIFE)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

15228 MARLBORO PIKE UPPER MARLBORO, MD. 20772

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

MARYLAND VETERAN CEMETERY 5/17/96 CHELTANHAM, MD.

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Larry H. Reese

22. Name and Address of Facility

WM. REESE & SONS MORTUARY, P.A.
821 WEST ST. ANNAPOLIS, MD. 21401

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Terminal Prostate Cancer

Due to (or as a consequence of):

b. dehydration

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

1 1/2
7 days

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No25. Was case referred to medical examiner?
1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined28a. Date of Injury
(Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier
(Check only one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Dr. Bowen M. Attending

29c. License number

D-24535

29d. Date signed (Month, Day, Year)

5/13/96

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Laxmi N. Berwa M.D. 7700 Old Branch Ave. Clinton, Md

31. Date filed (Month, Day, Year)

MAY 17 1996

32. Registrar's Signature

Julia Davidson-Randall

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 15763

Amended # 20a.P.G.C. 5-15-96 CR

Certificate of Death

Reg. No.

| | | | | | | | | |
|---|--|---|---|---|--|---|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
JOANN MCDOW | | | | 2. Date of Death
Month Day Year
APRIL 24, 1996 | | 3. Time of Death
2100 PM | |
| | 4a. Facility Name (If not institution, give street and number)
RAMP 295 to ROUTE 210-ROADWAY | | | | 4b. City, Town, or Location of Death
OXON HILL | | 4c. County of Death
PRINCE GEORGES | |
| Funeral
Director | 5. Social Security Number
579-74-0420 | | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)
43 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth (Month, Day, Year)
SEPT 3, 1952 | 9. Birthplace (State or Foreign Country)
NORTH CAROLINA |
| | Usual Residence of Decedent | | | | | | | |
| 10a. State
DC | | 10b. County
N/A | | 10c. City, Town or Location
WASHINGTON | | | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | |
| 10e. Street and Number
120 DANBERRY STREET, S.W. | | | | 10f. Zip Code
20032 | | 10g. Citizen of What Country?
U.S.A. | | |
| 11. Marital Status
<input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: BLACK | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 11th College (1-4or 5+) | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
UNEMPLOYED | | | 16b. Kind of Business/Industry
N/A | | |
| 17. Father's Name (First, Middle, Last)
WILLIAMS J. HIGGENS | | | | 18. Mother's Name (First, Middle, Maiden Surname)
FANNIE BYRD | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
FANNIE BYRD (MOTHER) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
120 DANBERRY STREET, S.W.; WASHINGTON, D.C. 20032 | | | | |
| 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
RIVERDALE PARK CREMATORY | | Date
5-1-96 | | 20c. Location - City or Town, State
RIVERDALE, MARYLAND | |
| 21. Signature of Funeral Service Licensee
<i>Belva J. Jenkins</i> | | | | 22. Name and Address of Facility
JOHNSON & JENKINS FUNERAL HOME, INC.
716 KENNEDY STREET, N.W.; WDC 20011 | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
e. Multiple Injuries
Due to (or as a consequence of):

Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. | | | | | | | | Approximate Interval Between Onset and Death |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | |
| | | | | | | 24a. Was an autopsy performed?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | |
| | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | |
| 25. Was case referred to medical examiner?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) AT SCENE | | | | | | |
| 27. Manner of Death
<input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year)
4/24/96 | | 28b. Time of Injury
7:48 PM | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred
Subject passenger in vehicle/vehicle impact to Route 295 ramp to Route 210 |
| 29a. Certifier (Check only one)
<input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier
<i>Theodore M. King</i> | | 29c. License number
O.C.M.E. | | 29d. Date signed (Month, Day, Year)
APRIL 25, 1996 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
THEODORE M. KING 111 Penn Street, Baltimore, Maryland 21201 | | | | | | | | |
| 31. Date filed (Month, Day, Year)
MAY 10 1996 | | | | 32. Registrar's Signature
<i>John Anderson</i> | | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

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Physician
/Medical
Examiner

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 15764

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

RUBY CECELIA MUSGROVE

2. Date of Death

Month Day Year
MAY 02 1996

3. Time of Death

4:16AM

4a. Facility Name (If not institution, give street and number)

FORT WASHINGTON HOSPITAL

4b. City, Town, or Location of Death

Ft. Washington

4c. County of Death

Prince George's

5. Social Security Number

121-36-7782

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

51

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
April 2, 1945

9. Birthplace (State or Foreign Country)

New Rochelle, N.Y.

Usual Residence of Decedent

10a. State

Maryland

10b. County

Charles

10c. City, Town or Location

Waldorf

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

1111 Falmouth Road

10f. Zip Code

20601

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify:
Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

3

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Receptionist

16b. Kind of Business/Industry

Private

17. Father's Name (First, Middle, Last)

Thomas Tyler

18. Mother's Name (First, Middle, Maiden Surname)

Ruby Turner

19a. Informant's Name/Relationship (Type, Print)

Robert L. Musgrove, Jr.

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1111 Falmouth Road, Waldorf, Maryland 20601

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Ft. Lincoln Cemetery

Date

5/7/96

20c. Location - City or Town, State

Brentwood, MD

21. Signature of Funeral Service Licensee

John T. Stewart III

22. Name and Address of Facility

STEWART FUNERAL HOME, Inc.

4001 Benning Road, N. E., Washington, D. C.

23. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. RESPIRATORY FAILURE

Due to (or as a consequence of):

b. PNEUMONIA

Due to (or as a consequence of):

c. METASTATIC BREAST CANCER

Due to (or as a consequence of):

d.

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Victor E. Herry MD

29c. License number

D20986

29d. Date signed (Month, Day, Year)

5-3-96

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

VICTOR HERRY MD 1328 SOUTHERN AVE. S.E. SUITE #302 WASHINGTON, DC 20032

31. Date filed (Month, Day, Year)

MAY 07 1996

32. Registrar's Signature

*John T. Stewart III*State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

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Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 15765

Certificate of Death

Reg. No.

| | | | | | | | | | |
|--|---|---|--|---|---|--|---|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Francis A. Marceron | | | | 2. Date of Death
Month May Day 03 Year 1996 | | 3. Time of Death
8:42 pm | | |
| | 4a. Facility Name (If not institution, give street and number)
Church and Home Hospital | | | | 4b. City, Town, or Location of Death
Baltimore | | 4c. County of Death
Baltimore City | | |
| Funeral
Director | 5. Social Security Number
578-56-8114 | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday)
51 Yrs. | | 8. Date of Birth (Month, Day, Year)
Dec. 11, 1944 | | |
| | 9. Birthplace (State or Foreign Country)
Washington, DC | | 10a. State
MD | | 10b. County
Baltimore City | | 10c. City, Town or Location
Baltimore | | |
| Usual Residence of Decedent | | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 10e. Street and Number
208 S. Madeira Street | | 10f. Zip Code
21231 | | 10g. Citizen of What Country?
U.S.A. | |
| 11. Marital Status
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: White | | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 11 College (1-4 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Printer | | 16b. Kind of Business/Industry
Print Shop | | 17. Father's Name (First, Middle, Last)
Francis Alloysious Marceron, Sr. | | 18. Mother's Name (First, Middle, Maiden Surname)
Lucille King | |
| 19a. Informant's Name/Relationship (Type, Print)
Francis A. Marceron, III | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
5621 Hawthorne Street, Cheverly, Maryland 20785 | | 20a. Method of Disposition
<input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Metropolitan Crematory 5/08/1996 | | 20c. Location - City or Town, State
Alexandria, Virginia | |
| 21. Signature of Funeral Service Licensee
[Signature] | | 22. Name and Address of Facility
Francis Gasch's Sons Funeral Home, P.A.
4739 Baltimore Avenue, Hyattsville, MD 20781 | | 23a. Pertinent disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

e. Gastrointestinal bleeding
Due to (or as a consequence of):
b. Hepatic encephalopathy
Due to (or as a consequence of):
c. Cirrhosis
Due to (or as a consequence of):
d. | | Approximate Interval Between Onset and Death
5 days
10 days
3 years | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Chronic obstructive pulmonary disease | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown | | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day, Year)
 | | 28b. Time of Injury
M | |
| 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred
 | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
 | | 28f. Location (Street and Number or Rural Route Number, City or Town, State)
 | | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier
Richard C. Hui MD | | 29c. License number
D43273 | | 29d. Date signed (Month, Day, Year)
May, 03, 1996 | | | |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)
Richard C. Hui 600 N. Wolfe Street, Baltimore MD 21287 | | 31. Date filed (Month, Day, Year)
MAY 07 1996 | | 32. Registrar's Signature
[Signature] | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

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Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

10

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 15766

Certificate of Death

Reg. No.

| | | | | | | | | |
|--|--|---|---|--|--|---|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Esther M. McGowan | | | | 2. Date of Death
Month Day Year
April 24 1996 | | 3. Time of Death
7:45 AM | |
| | 4a. Facility Name (If not institution, give street and number)
1417 Knightsbridge Turn | | | | 4b. City, Town, or Location of Death
Crofton | | 4c. County of Death
Anne Arundel | |
| Funeral
Director | 5. Social Security Number
579 01 9186 | | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)
86 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth (Month, Day, Year)
July 31 1909 | 9. Birthplace (State or Foreign Country)
Pennsylvania |
| | Usual Residence of Decedent | | | | | | | |
| To Be Completed by Funeral Director | 10a. State
Maryland | | 10b. County
Anne Arundel | | 10c. City, Town or Location
Crofton | | 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| | 10e. Street and Number
1417 Knightsbridge Turn | | | | 10f. Zip Code
21114 | | 10g. Citizen of What Country?
United States | |
| | 11. Marital Status
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: White | |
| | 15. Decedent's Education (Specify only highest grade completed)
12
Elementary/Secondary (0-12) College (1-4 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Manager | | | | 16b. Kind of Business/Industry
Restaurant | |
| | 17. Father's Name (First, Middle, Last)
Edward Boes | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Emma Buck | | | |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print)
Gail T. McGowan | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1417 Knightsbridge Turn Crofton Md. 21114 | | | |
| | 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Resurrection Cemetery | | Date
4/27/96 | | 20c. Location - City or Town, State
Clinton Maryland | |
| | 21. Signature of Funeral Service Licensee
Robert E. Evans Pres. | | | | 22. Name and Address of Facility
Robert E. Evans Funeral Home, P.A.
16000 Annapolis Rd. Bowie Md. 20715 | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. Gastrointestinal malignancy
Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of): | | | | | | | Approximate Interval Between Onset and Death
Unknown |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Alzheimer's disease | | | | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |
| 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how Injury occurred |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier
Angela Calle M.D. | | 29c. License number
D41479 | | 29d. Date signed (Month, Day, Year)
April 26, 1996 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Angela Calle M.D. 2568 A. Riva Rd. Annapolis Maryland | | | | | | | | |
| 31. Date filed (Month, Day, Year)
MAY 08 1996 | | 32. Registrar's Signature
John A. H. Randall | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

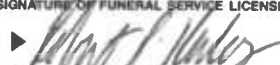
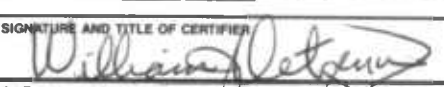
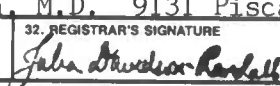
Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

96 15767

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|--|---|--|--|---|
| 1. DECEDENT'S NAME (First, Middle, Last)
John Francis McDermott | | | | 2. DATE OF DEATH
MONTH DAY YEAR
May 6, 1996 | | 3. TIME OF DEATH
11:20 A M | |
| 4. SOCIAL SECURITY NUMBER
291-16-1304 | | 5. SEX
1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
73 YRS. | | 7. DATE OF BIRTH (Month, Day, Year)
7-24-22 | |
| 9a. FACILITY NAME (If not institution, give street and number)
3419 24th Avenue | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
Temple Hills | | 9c. COUNTY OF DEATH
Prince George's | |
| 10a. STATE
Maryland | | | | 10b. COUNTY
Prince George's | | 10c. CITY, TOWN OR LOCATION
Temple Hills | |
| 10d. INSIDE CITY LIMITS?
1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | 10e. STREET AND NUMBER
3419 24th Avenue | | | |
| 10f. ZIP CODE
20748 | | | | 10g. CITIZEN OF WHAT COUNTRY?
USA | | | |
| 11. MARITAL STATUS
1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?
1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO
IF YES, GIVE WVR OR DATES
W.W. II | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify:
White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12) College (1-4 or 5 +)
1 | | 16. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
Union Lather | | 16b. KIND OF BUSINESS/INDUSTRY
Construction | | | |
| 17. FATHER'S NAME (First, Middle, Last)
John Francis McDermott, II | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Helen Lanphier | | | |
| 19a. INFORMANT'S NAME (Type/Print)
Jane L. McDermott | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
3419 24th Ave. Temple Hills, Maryland 20748 | | | |
| 20a. METHOD OF DISPOSITION
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
Maryland Veteran's Cem. 5-10-96 | | 20c. LOCATION — City or Town, State
Cheltenham, Maryland | | 20d. DATE | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
 | | | | 22. NAME AND ADDRESS OF FACILITY
George P. Kalas Funeral Home
6160 Oxon Hill Rd. Oxon Hill, Md. 20745 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Carcinoma of the Pancreas
DUE TO (OR AS A CONSEQUENCE OF):
Sequitally ill conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST
b. DUE TO (OR AS A CONSEQUENCE OF):
c. DUE TO (OR AS A CONSEQUENCE OF):
d. | | | | | | | Approximate Interval Between Onset and Death
2 months |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | 24a. WAS AN AUTOPSY PERFORMED?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | | | | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA
OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation
2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined
3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M | | 28c. INJURY AT WORK?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one)
1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
 | | | | 29c. LICENSE NUMBER
D-16129 | | 29d. DATE SIGNED (Month, Day, Year)
May 6, 1996 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
William J. Oetgen, M.D. 9131 Piscataway Rd. Suite 600 Clinton, Md. 20735 | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
MAY 09 1996 | | 32. REGISTRAR'S SIGNATURE
 | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 96 15768

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

RAYMOND LEE MARINER

2. Date of Death

Month
MAYDay
7Year
1996

3. Time of Death

9:00 AM

Funeral
Director

4a. Facility Name (If not institution, give street and number)

206 BRADLEY STREET

4b. City, Town, or Location of Death

HEBRON

4c. County of Death

WICOMICO

5. Social Security Number

221-14-6032

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

70

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)
4/17/26

9. Birthplace (State or Foreign Country)

DELAWARE

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

WICOMICO

10c. City, Town or Location

HEBRON

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

206 BRADLEY STREET

10f. Zip Code

21830

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☒ Yes 2 ☐ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: WHITE

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

8

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working
life. DO NOT use retired)

POULTRY FARMER

16b. Kind of Business/Industry

POULTRY

17. Father's Name (First, Middle, Last)

HARRY MARINER

18. Mother's Name (First, Middle, Maiden Surname)

BLANCHE CLENDANIEL

19a. Informant's Name/Relationship (Type, Print)

JOSEPHINE MARINER-WIFE

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

206 BRADLEY ST, HEBRON, MD. 21830

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

MARYLAND VETERANS CEM.

Date

5/10/96

20c. Location - City or Town, State

HURLOCK, MARYLAND

21. Signature of Funeral Service Licensee

22. Name and Address of Facility
MELSON FUNERAL SERVICES
FRANKFORD, DE. 1994523a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Approximate
Interval Between
Onset and DeathImmediate Cause (Final
disease or condition
resulting in death)e. Cardiac Arrest
Due to (or as a consequence of):Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Lastb. Cor Pulmonale
Due to (or as a consequence of):c. Chronic obstructive pulmonary disease
Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Sleep apnea

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation
6 ☐ Could not be
determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)29. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

D19289

5/7/96

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Chayton L. Raab MD PO Box 2636 Salisbury MD 21801

31. Date filed (Month, Day, Year)

MAY 08 1996

32. Registrar's Signature

Judy Davidson-Randall

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural," or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

96 15769

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
MARIE ELEANOR NELSON | | | | 2. DATE OF DEATH
MONTH MAY DAY 2 YEAR 1996 | | 3. TIME OF DEATH
12 00 P M | |
| 4. SOCIAL SECURITY NUMBER
218-18-7445 | | 5. SEX
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | 6. AGE (In yrs. last birthday)
73 YRS. | IF UNDER 1 YEAR
MONTHS _____ DAYS _____ | IF UNDER 24 HRS.
HOURS _____ MIN. _____ | 7. DATE OF BIRTH
(Month, Day, Year)
MAY 1 1923 | |
| 8. BIRTHPLACE (State or Foreign Country)
MARYLAND | | | | 9a. FACILITY NAME (If not institution, give street and number)
JOHN DEATON | | 9b. CITY, TOWN OR LOCATION OF DEATH
BALTIMORE | |
| 9c. COUNTY OF DEATH
CITY | | | | 10a. STATE
MARYLAND | | 10b. COUNTY
ANNE ARUNDEL | |
| 10c. CITY, TOWN OR LOCATION
CHURCHTON | | | | 10d. INSIDE CITY LIMITS?
<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | 10e. STREET AND NUMBER
1220 CHESAPEAKE DRIVE | |
| 10f. ZIP CODE
20733 | | | | 10g. CITIZEN OF WHAT COUNTRY?
US | | 11. MARITAL STATUS
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify:
BLACK | |
| 15. DECEDENT'S EDUCATION
(Specify only highest grade completed)
Elementary/Secondary (0-12) 6th College (13-16 or 17+) 0 | | | | 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.)
HOMEMAKER | | 16b. KIND OF BUSINESS/INDUSTRY
OWN HOME | |
| 17. FATHER'S NAME (First, Middle, Last)
SAMUEL J. GARNETT | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
MYRTLE STANLEY | | | |
| 19a. INFORMANT'S NAME (Type/Print)
LEROY JOHNSON | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1220 CHESAPEAKE DR. CHURCHTON, MD. 20733 | | | |
| 20a. METHOD OF DISPOSITION
<input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
METRO CREMATORY | | 20c. LOCATION — City or Town, State
5/8/96 BALTIMORE, MD. | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
Harry D. Reese | | | | 22. NAME AND ADDRESS OF FACILITY
WM. REESE & SONS MORTUARY, P.A.
821 WEST ST. ANNAPOLIS, MD. 21401 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. CHRONIC OBSTRUCTIVE PULMONARY DIS
DUE TO (OR AS A CONSEQUENCE OF):
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST
b. DUE TO (OR AS A CONSEQUENCE OF):
c. DUE TO (OR AS A CONSEQUENCE OF):
d. | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
DIABETES MELLITUS, PNEUMONIA | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
<input type="checkbox"/> YES <input type="checkbox"/> NO | | | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA
OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY
(Month, Day, Year) | | 28b. TIME OF INJURY
M | | 28c. INJURY AT WORK?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | 29a. CERTIFIER (Check only one)
<input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
Brian C. Wallace MD | | | | 29c. LICENSE NUMBER
D31136 | | 29d. DATE SIGNED (Month, Day, Year)
MAY 2, 1996 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
BRIAN C. WALLACE, MD, 611 S. CHARLES ST., BALTIMORE, MD 21230 | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
MAY 10 1996 | | | | 32. REGISTRAR'S SIGNATURE
John Davidson-Randall | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 15770

Certificate of Death

Reg. No.

| | | | | | | | | | | |
|---|---|--|--|---|--|--------------------------|---|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
GREGORY BRUCE NULPH | | | | 2. Date of Death
Month Day Year
APRIL 28 1996 | | | | 3. Time of Death
5:50PM | |
| | 4a. Facility Name (If not institution, give street and number)
National Institutes of Health-Clinical Ctr | | | | 4b. City, Town, or Location of Death
Bethesda | | | | 4c. County of Death
Montgomery County | |
| Funeral
Director | 5. Social Security Number
202-58-6238 | | 6. Sex
1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 7. Age (In yrs. last birthday)
30 Yrs. | | 8. Date of Birth (Month, Day, Year)
August 6, 1965 | | 9. Birthplace (State or Foreign Country)
Grove City, Pennsylvania | |
| | Usual Residence of Decedent | | | | 10a. State
Pennsylvania | | | | 10b. County
Mercer | |
| To Be Completed by Funeral Director | 10c. City, Town or Location
Wolf Creek Township | | | | 10d. Inside City Limits
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | |
| | 10e. Street and Number
1572 Sandy Lake Road | | | | 10f. Zip Code
16133 | | | | 10g. Citizen of What Country?
United States of America | |
| | 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever In U.S. Armed Forces?
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No
If Yes, Give Year or Dates: Active | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | | 14. Race - American Indian, Black, White, etc.
Specify: White | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (1-4or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Helicopter Crew Chief | | | | 16b. Kind of Business/Industry
United States Air Force | |
| | 17. Father's Name (First, Middle, Last)
Wallace Bruce Nulph | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Virginia L. Allen | | | | | |
| | 19a. Informant's Name/Relationship (Type, Print)
Rachel Hough Wife | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
109 Apple Way, Grove City, Pennsylvania 16127 | | | | | |
| | 20a. Method of Disposition
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Crestview Memorial Park | | Data
May 3, 1996 | | 20c. Location - City or Town, State
Grove City, Pennsylvania | | | |
| | 21. Signature of Funeral Service Licensee #M00690
Dorinda Cousen | | | | 22. Name and Address of Facility
Cunningham Funeral Home, Inc.
306 Bessemer Avenue, Grove City, Pennsylvania 16127 | | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. RESPIRATORY FAILURE
Due to (or as a consequence of):
b. DIFFUSE ALVEOLAR HEMORRHAGE
Due to (or as a consequence of):
c. BIPHOTOPHIC LEUKEMIA
Due to (or as a consequence of):
d. | | | | Approximate Interval Between Onset and Death | | | | | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown | | | | | |
| | | | | 24a. Was an autopsy performed?
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | 24b. Were autopsy findings available prior to completion of cause of death?
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | |
| 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one)
Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death
1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation
2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined
3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | |
| | | | | 28d. Describe how injury occurred | | | | | | |
| | | | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | |
| 29a. Certifier
(Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | 29b. Signature and title of certifier
Andre P. N. Kalil | | | | 29c. License number
ME 0063969 | | |
| | | | | 29d. Date signed (Month, Day, Year)
4/15/96 | | | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
ANDRE KALIL, M.D. NATIONAL INSTITUTES OF HEALTH, BETHESDA, MD. 20892 | | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
MAY 09 1996 | | | | 32. Registrar's Signature
John Andrew Barlett | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 15771

Certificate of Death

Reg. No.

| | | | | | | | | | |
|---|---|---|--|---|---|--------------------------------------|---|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
NORMAN CHARLES NORTH | | | 2. Date of Death
Month May Day 14 Year 1996 | | 3. Time of Death
7:30 PM | | | |
| | 4a. Facility Name (If not institution, give street and number)
The Memorial Hospital at Easton | | | 4b. City, Town, or Location of Death
Easton | | 4c. County of Death
Talbot | | | |
| Funeral
Director | 5. Social Security Number
213-12-0100 | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday)
79 Yrs. | | 8. Date of Birth (Month, Day, Year)
APR. 5, 1917 | | |
| | 9. Birthplace (State or Foreign Country)
MARYLAND | | 10a. State
MD | | 10b. County
TALBOT | | 10c. City, Town or Location
EASTON | | |
| To Be Completed by Funeral Director | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 10e. Street and Number
339 N. WASHINGTON ST. | | 10f. Zip Code
21601 | | 10g. Citizen of What Country?
USA | | |
| | 11. Marital Status
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: WHITE | | |
| To Be Completed by Physician/Medical Examiner | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 10 College (1-4or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
INSPECTOR | | 16b. Kind of Business/Industry
MARYLAND STATE HIGHWAY | | 17. Father's Name (First, Middle, Last)
ROBERT RISDON NORTH | | |
| | 18. Mother's Name (First, Middle, Maiden Surname)
EFFIE TARR | | 19a. Informant's Name/Relationship (Type, Print)
ELLA R. NORTH | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
339 N. WASHINGTON ST., EASTON, MD 21601 | | 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | |
| Physician
/Medical
Examiner | 20b. Place of Disposition (Name of cemetery, crematory or other place)
FAIRVIEW CEMETERY | | 20c. Date
5-17 | | 20d. Location - City or Town, State
CORDOVA, MD | | 21. Signature of Funeral Service Licensee
JOHN R. MERCERON | | |
| | 22. Name and Address of Facility
FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME | | 22b. Address
200 S. HARRISON ST., EASTON, MD 21601 | | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
GI Hemorrhage ? CAUSE | | Approximate Interval Between Onset and Death
1-2 HRS | | |
| To Be Completed by Physician/Medical Examiner | 23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
A.S. IN D
C.O.P.E. | | 23c. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| | 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation
<input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined
<input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day Year) | | |
| State Registrar | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | | 28e. Location (Street and Number or Rural Route Number, City or Town, State) | | |
| | 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier
Stephen P. Carney | | 29c. License number
201225 | | 29d. Date signed (Month, Day, Year)
5-15-96 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
STEPHEN P. CARNEY, M.D., 509 IDLEWILD AVENUE, EASTON, MD 21601 | | 31. Date filed (Month, Day, Year)
MAY 16 1996 | | 32. Registrar's Signature
John Andrew Randall | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 902-58.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 15772

Certificate of Death

Reg. No.

| | | | | | | | | |
|---|--|---|---|--|---|-------------------------------|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
James ONEAL | | | | 2. Date of Death
Month May Day 12 Year 1996 | | 3. Time of Death
11:02p | |
| | 4e. Facility Name (If not institution, give street and number)
Memorial Hospital @ Easton | | | | 4b. City, Town, or Location of Death
Easton | | 4c. County of Death
Talbot | |
| Funeral
Director | 5. Social Security Number
261-01-8899 | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday)
91 Yrs. | | 8. Date of Birth (Month, Day, Year)
Mar. 5, 1905 | |
| | 9. Birthplace (State or Foreign Country)
Georgia | | 10e. State
Maryland | | 10b. County
Queen Annes | | 10c. City, Town or Location
Queenstown | |
| To Be Completed by Funeral Director | 10e. State
Maryland | | 10b. County
Queen Annes | | 10c. City, Town or Location
Queenstown | | 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| | 10e. Street and Number
132 Scottown Road | | | | 10f. Zip Code
21658 | | 10g. Citizen of What Country?
USA | |
| | 11. Marital Status
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: Black | |
| | 15. Decedent's Education (Specify only highest grade completed)
5th | | | | 16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Taxi Cab Driver | | 16b. Kind of Business/Industry
Taxi Driver | |
| | 17. Father's Name (First, Middle, Last)
Peter Oneal | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Josphine Adkins | | | |
| | 19e. Informant's Name/Relationship (Type, Print)
Elois Turner | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
132 Scottown Road, Queenstown, Md. 21658 | | | |
| | 20e. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Robinson A.M.E. Church | | 20c. Location - City or Town, State
Grasonville, Md. | | 20d. Date
5/16/96 | |
| | 21. Signature of Funeral Service Licensee
 | | | | 22. Name and Address of Facility
Bennie Smith Funeral Home
P.O. Box 1687, Easton, MD. 21601 | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. SEPTIC SHOCK
Due to (or as a consequence of):
b. ACUTE URINARY TRACT INFECTION
Due to (or as a consequence of):
c. ASTHMATIC BRONCHITIS
Due to (or as a consequence of):
d. | | | | | | | |
| | Approximate Interval Between Onset and Death
48 hrs
3 DAYS
YEARS | | | | | | | |
| To Be Completed by Physician/Medical Examiner | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
CHRONIC OBSTRUCTIVE PULMONARY DISEASE
ALZHEIMER'S DEMENTIA | | | | | | 23b. Did tobacco use contribute to the cause of death?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | |
| | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| | 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| | 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28d. Describe how injury occurred | | | |
| | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| | 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | |
| | 29b. Signature and title of certifier
 | | | | 29c. License number
D26350 | | 29d. Date signed (Month, Day, Year)
5/13/96 | |
| | 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)
WM S BREMER MD
800 S. TALBOT ST.
ST. MICHAELS MD 21663 | | | | | | | |
| | State Registrar | 31. Date filed (Month, Day, Year)
MAY 16 1996 | | | | 32. Registrar's Signature
 | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 15773

Certificate of Death

Reg. No.

| | | | | | | | | | | | | |
|--|--|---|---|---|--|---|---|---|--|--|---|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
JULIA M. PARNELL | | | | 2. Date of Death
Month 5 Day 11 Year 96 | | | | 3. Time of Death
1:25AM | | | |
| | 4a. Facility Name (If not institution, give street and number)
822 Chesapeake Avenue | | | | 4b. City, Town, or Location of Death
Annapolis | | | | 4c. County of Death
Anne Arundel | | | |
| Funeral
Director | 5. Social Security Number
218-28-8687 | | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday)
64 Yrs. | | 8. Date of Birth (Month, Day, Year)
March 18 1932 | | 9. Birthplace (State or Foreign Country)
Maryland | | | |
| | Usual Residence of Decedent | | | | | | | | | | | |
| To Be Completed by Funeral Director | 10a. State
MD | | 10b. County
Anne Arundel | | 10c. City, Town or Location
Annapolis | | | | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | |
| | 10e. Street and Number
822 Chesapeake Avenue | | | | 10f. Zip Code
21403 | | 10g. Citizen of What Country?
United States | | | | | |
| | 11. Marital Status
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc.
Specify: White | | | | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (1-4or 5+) | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Cashier | | | 16b. Kind of Business/Industry
Drug Store | | | | | |
| | 17. Father's Name (First, Middle, Last)
Louis Hopkins | | | | 18. Mother's Name (First, Middle, Maiden Summa)
Josephine Chaney | | | | | | | |
| | 19a. Informant's Name/Relationship (Type, Print)
Robert Parnell/Husband | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
822 Chesapeake Avenue Annapolis, MD 21403 | | | | | | | |
| | 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Cedar Bluff Cemetery May 15 1996 | | Data | | 20c. Location - City or Town, State
Annapolis, Maryland | | | | | |
| | 21. Signature of Funeral Service Licensee
 | | | | 22. Name and Address of Facility
John M. Taylor Funeral Home, Inc.
147 Duke Of Gloucester St. Annapolis, MD 21401 | | | | | | | |
| | 23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. CHOLANGIO CARCINOMA
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of): | | | | | | | | | | Approximate Interval Between Onset and Death | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
DM, CAD, Hypothyroid | | | | | | | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | |
| 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | | | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier
 | | 29c. License number
24768 | | 29d. Date signed (Month, Day, Year)
5/11/96 | | | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
DABBS 600 RIDGELY AVE, ANNAPOLIS | | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
MAY 13 1996 | | 32. Registrar's Signature
 | | | | | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 15774

Certificate of Death

Reg. No.

| | | | | | | | | | | |
|--|---|--------------------------------------|---|---|--|-------------------------------------|---|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
<i>William Eugene Ferrar PADGETT Sr.</i> | | | | 2. Date of Death
Month <i>May</i> Day <i>8</i> Year <i>1996</i> | | | | 3. Time of Death
<i>3:58P</i> | |
| | 4a. Facility Name (If not institution, give street and number)
<i>DOCTORS HOSPITAL</i> | | | | 4b. City, Town, or Location of Death
<i>LANHAM</i> | | | | 4c. County of Death
<i>PRINCE GEORGES</i> | |
| Funeral
Director | 5. Social Security Number
<i>579 20 1145</i> | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday)
<i>73</i> Yrs. | | 8. Date of Birth (Month, Day, Year)
<i>JAN 5, 1923</i> | | 9. Birthplace (State or Foreign Country)
<i>D.C. Washington</i> | |
| | Usual Residence of Decedent | | | | | | | | | |
| 10a. State
<i>MD.</i> | | 10b. County
<i>PRINCE GEORGES</i> | | 10c. City, Town or Location
<i>LANHAM</i> | | | | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | |
| 10e. Street and Number
<i>7608 FINNS LANE</i> | | | | 10f. Zip Code
<i>20706</i> | | | | 10g. Citizen of What Country?
<i>U.S.A.</i> | | |
| 11. Marital Status
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | | 12. Was Decedent Ever in U.S. Armed Forces?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc.
Specify: <i>WHITE</i> | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) <i>12</i> College (1-4 or 5+) <i></i> | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
<i>TESTMAN</i> | | | | 16b. Kind of Business/Industry
<i>C&P TELEPHONE</i> | | |
| 17. Father's Name (First, Middle, Last)
<i>LESTER EUGENE PADGETT</i> | | | | | 18. Mother's Name (First, Middle, Maiden Surname)
<i>GWENDOLYN MARY FERRAR</i> | | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
<i>CHARLEEN DIGGS</i> | | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
<i>121 FRANKLIN AVE., SILVER SPRING, MD. 20901</i> | | | | | |
| 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
<i>George Washington Cem. May 13, 1996 Adelphi, Md.</i> | | | 20c. Location - City or Town, State | | | | |
| 21. Signature of Funeral Service Licensee
<i>[Signature]</i> | | | | | 22. Name and Address of Facility
<i>TAKOMA FUNERAL HOME INC 254 CARROLL ST N.W. WASHINGTON, D.C. 20012</i> | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. <i>ANOXIC CEREBRAL DEGENERATION</i> 18 days
Due to (or as a consequence of):
b. <i>CARDIOPULMONARY ARREST</i> 18 days prior
Due to (or as a consequence of):
c. <i>ACUTE SUBENDOCARDIAL MYOCARDIAL INFARCTION</i> 18 days
Due to (or as a consequence of):
d. <i>HYPERTENSIVE ISCHEMIC CARDIOMYOPATHY</i> 2 years.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> 1 Yes <input type="checkbox"/> 2 No <input checked="" type="checkbox"/> 3 Probably <input type="checkbox"/> 4 Unknown

24a. Was an autopsy performed?
<input type="checkbox"/> 1 Yes <input checked="" type="checkbox"/> 2 No

24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> 1 Yes <input checked="" type="checkbox"/> 2 No | | | | | | | | | | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> 1 Yes <input checked="" type="checkbox"/> 2 No | | | | 26. Place of Death (Check only one)
Hospital: <input checked="" type="checkbox"/> 1 Inpatient <input type="checkbox"/> 2 ER/Outpatient <input type="checkbox"/> 3 DOA Other: <input type="checkbox"/> 4 Nursing Home <input type="checkbox"/> 5 Residence <input type="checkbox"/> 6 Other (Specify) | | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> 1 Natural <input type="checkbox"/> 5 Pending investigation
<input type="checkbox"/> 2 Accident <input type="checkbox"/> 6 Could not be determined
<input type="checkbox"/> 3 Suicide <input type="checkbox"/> 4 Homicide | | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
<i>M</i> | | 28c. Injury at Work?
<input type="checkbox"/> 1 Yes <input checked="" type="checkbox"/> 2 No | | 28d. Describe how injury occurred | |
| | | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | |
| 29b. Signature and title of certifier
<i>[Signature]</i> M.D. | | | | | 29c. License number
<i>1207479</i> | | 29d. Date signed (Month, Day, Year)
<i>May 8, 1996</i> | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
<i>Thomas G. Maloney M.D., 4814 71st Avenue, Hyattsville, MD 20784</i> | | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
<i>MAY 10 1996</i> | | | | | 32. Registrar's Signature
<i>[Signature]</i> | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 15775

Certificate of Death

Reg. No.

| | | | | | | | | |
|---|--|---|---|--------------------------------------|--|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
PHYLLIS RENEE PARKER | | | | 2. Date of Death
Month Day Year
APRIL 30, 1996 | | 3. Time of Death
4:20 PM | |
| | 4a. Facility Name (If not institution, give street and number)
1828 METZEROTT APT. 203 | | | | 4b. City, Town, or Location of Death
ADELPHI | | 4c. County of Death
Prince Georges | |
| Funeral
Director | 5. Social Security Number
579-92-2817 | | 6. Sex
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)
34 | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth
(Month, Day, Year)
Dec. 16, 1961 | 9. Birthplace (State or Foreign Country)
Wash., DC |
| | Usual Residence of Decedent | | | | | | | |
| To Be Completed by Funeral Director | 10a. State
MD | 10b. County
Prince Georges | 10c. City, Town or Location
Adelphi | | | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | |
| | 10e. Street and Number
1828 Metzertott Rd. #203 | | | | 10f. Zip Code
20783 | | 10g. Citizen of What Country?
USA | |
| | 11. Marital Status
1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: Black | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) College (1-4 or 5+)
2 | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Secretary | | 16b. Kind of Business/Industry
United Communications System | | | |
| | 17. Father's Name (First, Middle, Last)
Robert Parker | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Dolores Hebron | | | |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print)
Dolores Parker | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
2008 Evansdale Drive, Adelphi, MD 20783 | | | |
| | 20a. Method of Disposition
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Ft. Lincoln Cemetery | | Date
5-6-96 | 20c. Location - City or Town, State
Brentwood, Maryland | | |
| | 21. Signature of Funeral Service Licensee
J. P. Marshall | | | | 22. Name and Address of Facility
Marshall's Funeral Home, Inc.
4217 9th St. N.W., Wash., DC 20011 | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. STRANGULATION, BLUNT FORCE TRAUMA AND
Due to (or as a consequence of):
b. STABWOUND TO NECK
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d. | | | | | | | Approximate Interval Between Onset and Death |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |
| 25. Was case referred to medical examiner?
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28. Place of Death (Check only one)
Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death
1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation
2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined
3 <input type="checkbox"/> Suicide 4 <input checked="" type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day, Year)
FEBRUARY 26 | | 28b. Time of Injury
FOUR FOUR P M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred
STABBED
SUBJECT STRANGLED, STABBED AND |
| 29e. Certifier (Check only one)
1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier
Morgue Examiner | | 29c. License number
O.C.M.E. | | 29d. Date signed (Month, Day, Year)
MAY 01, 1996 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Morgue Examiner 111 Penn Street, Baltimore, Maryland 21201 | | | | | | | | |
| 31. Date filed (Month, Day, Year)
MAY 06 1996 | | 32. Registrar's Signature
John H. ... | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

96 15776

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|--|---|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last)
Mary T Perrygo | | | | 2. DATE OF DEATH
MONTH DAY YEAR
May 7 1996 | | 3. TIME OF DEATH
6:35 P. M. | |
| 4. SOCIAL SECURITY NUMBER
579-03-8002 | | 5. SEX
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
85 YRS. | | 7. DATE OF BIRTH (Month, Day, Year)
July 17, 1910 Maryland | |
| 9a. FACILITY NAME (If not institution, give street and number)
ST. Mary's Nursing Center | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
Leonardtwn | | 9c. COUNTY OF DEATH
ST. Mary's | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE
Maryland | | 10b. COUNTY
St. Mary's | | 10c. CITY, TOWN OR LOCATION
Leonardtwn | | 10d. INSIDE CITY LIMITS?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 10e. STREET AND NUMBER
Rt. 3, Box 30-B | | | | 10f. ZIP CODE
20650 | | 10g. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 11. MARITAL STATUS
1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12) 8
College (1-4 or 5+) _____ | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
Homemaker | | 16b. KIND OF BUSINESS/INDUSTRY
Own Home | | | |
| 17. FATHER'S NAME (First, Middle, Last)
Louis Leibold | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Mary Silverson | | | |
| 19a. INFORMANT'S NAME (Type/Print)
Charles L. Perrygo | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Rt. 3, Box 30-B, Leonardtown, Md. 20650 | | | |
| 20a. METHOD OF DISPOSITION
1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
St. Barnabas Epis. Church Cem. 5/11/96 | | 20c. LOCATION — City or Town, State
Temple Hills, Md. | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
 | | | | 22. NAME AND ADDRESS OF FACILITY
George P. Kalas Funeral Home
6160 Oxon Hill Rd. Oxon Hill, Md. 20745 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Cardio Respiratory Failure
DUE TO (OR AS A CONSEQUENCE OF):
b. DUE TO (OR AS A CONSEQUENCE OF):
c. DUE TO (OR AS A CONSEQUENCE OF):
d. DUE TO (OR AS A CONSEQUENCE OF):
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | Approximate Interval Between Onset and Death
2 hrs |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | 24a. WAS AN AUTOPSY PERFORMED?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | | | | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA
OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation
2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide
3 <input type="checkbox"/> Homicide 7 <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M | | 28c. INJURY AT WORK?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| | | 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. CERTIFIER (Check only)
1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
 | | | | 29c. LICENSE NUMBER
D33470 | | 29d. DATE SIGNED (Month, Day, Year)
5/8/96 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
Bhasker A. Jhaveri, M.D. 100 Exploration, Suite 1030, Lexington Park, Md. 20653 | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
MAY 9 1996 | | 32. REGISTRAR'S SIGNATURE
 | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 15777

| | | | | | | | | |
|---|---|---|--|--|---|---|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
KATIE C PARKER | | | | 2. Date of Death
Month Day Year
MAY 5 1996 | | 3. Time of Death
3:19pm | |
| | 4a. Facility Name (If not institution, give street and number)
DOCTORS COMMUNITY HOSPITAL | | | | 4b. City, Town, or Location of Death
LANHAM | | 4c. County of Death
PRINCE GEORGE'S CO. | |
| Funeral
Director | 5. Social Security Number
216-40-8255 | | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)
58 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth (Month, Day, Year)
04-29-38 | 9. Birthplace (State or Foreign Country)
Maryland |
| | Usual Residence of Decedent | | | | | | | |
| 10a. State
MD | | 10b. County
Prince George's | | 10c. City, Town or Location
Glendale | | | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | |
| 10e. Street and Number
12311 Annapolis Road | | | | 10f. Zip Code
20769 | | 10g. Citizen of What Country?
USA | | |
| 11. Marital Status
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc.
Specify: Black | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 8th College (1-4 or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Cook | | | 16b. Kind of Business/Industry
Private | |
| 17. Father's Name (First, Middle, Last)
Charles Wright | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Henrietta Pindell | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
Robert Parker/Husband | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
12311 Annapolis Road, Glendale, MD 20769 | | | | |
| 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Harmony Memorial Pk | | | 20c. Location - City or Town, State
5/11/96 Landover, MD | | |
| 21. Signature of Funeral Service Licensee
<i>Kimberly C. Buscose-Tonic</i> | | | | 22. Name and Address of Facility
J. B. Jenkins Funeral Home
7474 Landover Rd, Landover, MD 20785 | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. CARDIO PULMONARY ARREST
Due to (or as a consequence of):
b. SEPSIS
Due to (or as a consequence of):
c. ENDOCARDITIS
Due to (or as a consequence of):
d. HEPATOMA

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | | Approximate Interval Between Onset and Death
MINUTES
DAYS
WEEKS
MONTHS |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
CHRONIC RENAL FAILURE
METHICILLIN RESISTANT STAPH AUREUS | | | | | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |
| 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | 29b. Signature and title of certifier
<i>[Signature]</i> |
| 29c. License number
D31069 | | | | 29d. Date signed (Month, Day, Year)
May 7, 1996 | | | | |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)
Dr. George H. Bone 9602F M.L. King, Jr Highway Lanham, MD 20706 | | | | | | | | |
| 31. Date filed (Month, Day, Year)
MAY 09 1996 | | 32. Registrar's Signature
<i>[Signature]</i> | | | | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 96 15778

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Sallie Edward PROCTOR

2. Date of Death

May 8, 1996

Year

3. Time of Death

4:35AM

4a. Facility Name (If not institution, give street and number)

Doctor's Hospital

4b. City, Town, or Location of Death

Lanham

4c. County of Death

Prince George's

Funeral
Director

5. Social Security Number

244-84-4789

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

49 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

12-25-46

9. Birthplace (State or Foreign Country)

Virginia

Usual Residence of Decedent

10a. State

MD

10b. County

Prince George's

10c. City, Town or Location

Landover

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

3016 Brightseat Road

10f. Zip Code

20785

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12th

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Private

17. Father's Name (First, Middle, Last)

Jonah Hendricks

18. Mother's Name (First, Middle, Maiden Surname)

Lizzieanna Hargrove

19a. Informant's Name/Relationship (Type, Print)

Susie Forbes/Sister

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1311 Bellehaven Drive, Landover, MD 20785

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Harmony Memorial Pk

Date

5/13/96

20c. Location - City or Town, State

Landover, MD

21. Signature of Funeral Service Licensee

Kimberly Chusca Tonic

22. Name and Address of Facility

J. B. Jenkins Funeral Home

7474 Landover Rd, Landover, MD 20785

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Plural effusion

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

10 days

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Chronic Renal failure

Diabetes mellitus

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Physician2 ☐ Medical Examiner

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Dr. Chariyath Nath

29c. License number

D17875

29d. Date signed (Month, Day, Year)

May 8, 1996

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. Chariyath Nath 14300 Gallant Fox Lane Bowie, MD 20715

31. Date filed (Month, Day, Year)

MAY 09 1996

32. Registrar's Signature

John D. R. R. R.

State
Registrar

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural," or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

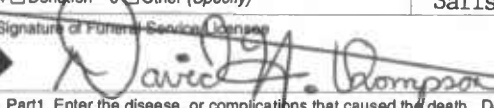
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

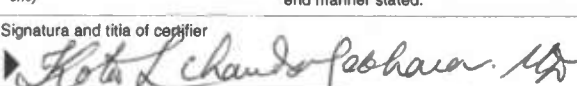
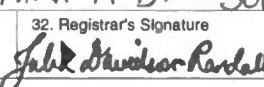
96 15779

Certificate of Death

Reg. No.

| | | | | | | | | | | | |
|---|--|--|--|--|---|--|--|---|--|---|---|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
KATHRYN -S- Porianda | | | 2. Date of Death
Month May Day 8 Year 1996 | | | 3. Time of Death
1900 | | | | |
| | 4e. Facility Name (If not institution, give street and number)
PENINSULA REGIONAL MEDICAL CENTER | | | 4b. City, Town, or Location of Death
SALISBURY | | | 4c. County of Death
WICOMICO | | | | |
| Funeral
Director | 5. Social Security Number
121-03-3070 | | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday)
81 Yrs. | | If Under 1 Year
Months Days | | If Under 24 Hrs.
Hours Min. | | |
| | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: White | | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (1-4or 5+) 0 | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Business Staff | | 16b. Kind of Business/Industry
Accounting |
| Usual Residence of Decedent | | | | | | | | | | | |
| 10a. State
Maryland | | | 10b. County
Wicomico | | | 10c. City, Town or Location
Salisbury | | | 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 10e. Street and Number
27206 Loch Lomond Court | | | | | | 10f. Zip Code
21801 | | | 10g. Citizen of What Country?
USA | | |
| 11. Marital Status
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc.
Specify: White | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (1-4or 5+) 0 | | | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Business Staff | | | 16b. Kind of Business/Industry
Accounting | | |
| 17. Father's Name (First, Middle, Last)
Steve Sarada | | | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Mary Hehla | | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
Alex Porianda/spouse | | | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
27206 Loch Lomond Ct., Salisbury, MD 21801 | | | | | |
| 20a. Method of Disposition
<input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Salisbury Crematory | | | | Date
5/11/96 | | 20c. Location - City or Town, State
Salisbury, MD | |
| 21. Signature of Funeral Service Licensee
 | | | | | | 22. Name and Address of Facility
Holloway Funeral Home
501 Snow Hill Rd., Salisbury, MD 21804 | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
e. ISCHEMIC BOWEL SYNDROME.
Due to (or as a consequence of):
b. CONGESTIVE HEART FAILURE
Due to (or as a consequence of):
c. EOSINOPHILIC MYOCARDITIS.
Due to (or as a consequence of):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | | | | | |
| 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | | | | | | | |
| 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
DIVERTICULOSIS.
RENAL FAILURE | | | | | | | | | | | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | | | | |
| 26. Place of Death (Check only one)
Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | | | | |
| 29b. Signature and title of certifier
 | | | | | | 29c. License number
D25091 | | | 29d. Date signed (Month, Day, Year)
5/8/1996. | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
KOTA L CHANDRASEKHARA M-D- 306. KAY AVE SALISBURY MD 21801. | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
MAY 10 1996 | | | | | | 32. Registrar's Signature
 | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

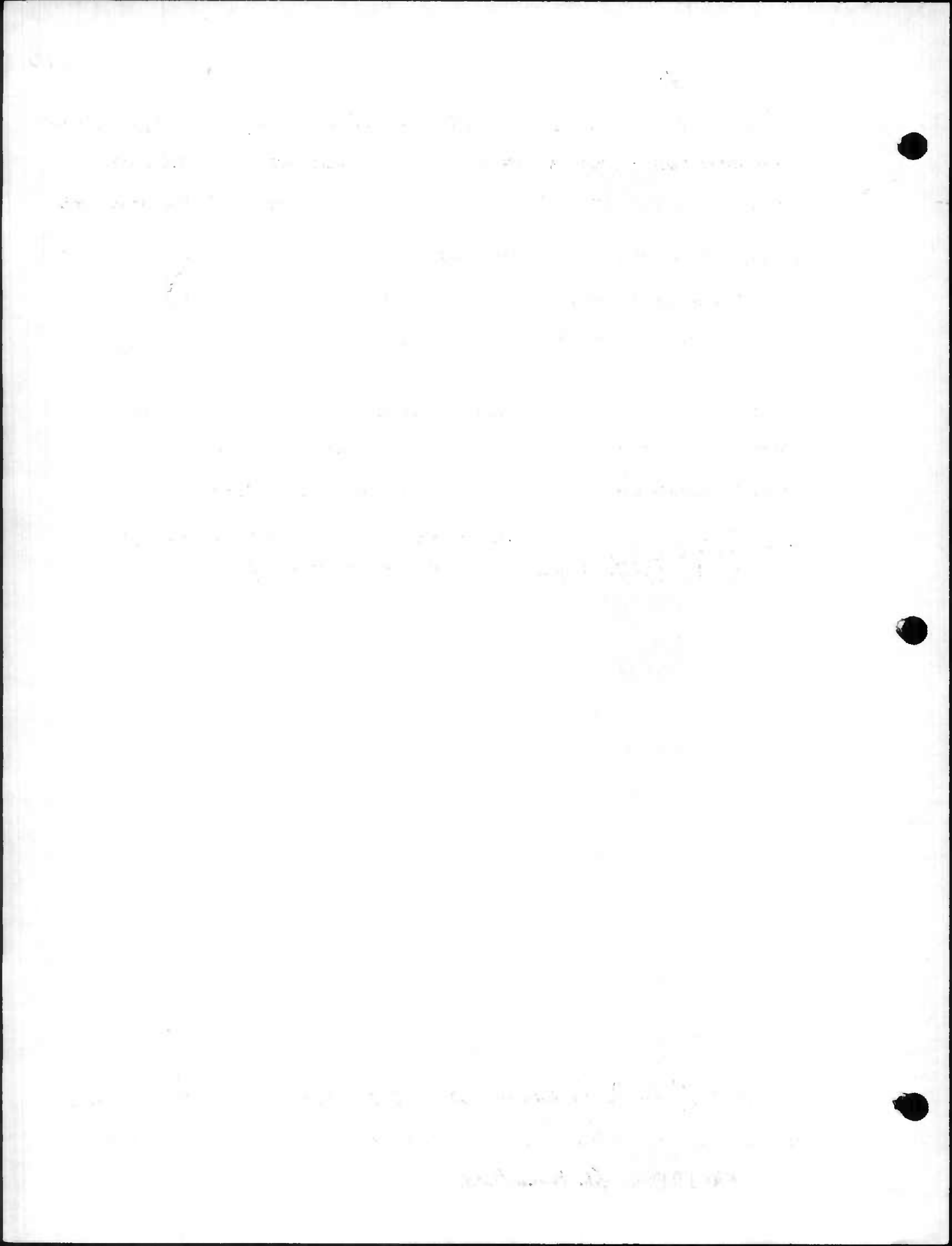
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To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar



96 15780

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
SHIRLEY M. PATTERSON | | | | 2. DATE OF DEATH
MONTH MAY DAY 12 YEAR 1996 | | 3. TIME OF DEATH
11:45A M | |
| 4. SOCIAL SECURITY NUMBER
217-28-4284 | | 5. SEX
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
62 YRS. | | 7. DATE OF BIRTH (Month, Day, Year)
DEC. 13, 1933 | |
| 8. BIRTHPLACE (State or Foreign Country)
MD. | | | | 9a. FACILITY NAME (If not institution, give street and number)
BERLIN NURSING & REHAB. CENTER | | 9b. CITY, TOWN OR LOCATION OF DEATH
BERLIN | |
| 9c. COUNTY OF DEATH
WORCESTER | | | | 10a. STATE
MD. | | 10b. COUNTY
WICOMICO | |
| 10c. CITY, TOWN OR LOCATION
PITTSVILLE | | | | 10d. INSIDE CITY LIMITS?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 10e. STREET AND NUMBER
4595 ELMER DAVIS LOOP | |
| 10f. ZIP CODE
21850 | | | | 10g. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 11. MARITAL STATUS
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify: WHITE | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12) 5 College (1-4 or 5+) | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
HOUSE-KEEPER | | 16b. KIND OF BUSINESS/INDUSTRY
HOTEL CHAIN | |
| 17. FATHER'S NAME (First, Middle, Last)
MILTON MORGAN | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
HILDA PARKER | | | |
| 19a. INFORMANT'S NAME (Type/Print)
LINDA GROSS | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
7269 W. RAINIER DR., PARSONSBURG, MD. 21849 | | | |
| 20a. METHOD OF DISPOSITION
<input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input checked="" type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) ENTOMBMENT | | | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
SPRINGHILL MEMORY GARDENS 5/14 | | 20c. LOCATION — City or Town, State
HEBRON, MARYLAND | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
<i>Gerard Brund</i> | | | | 22. NAME AND ADDRESS OF FACILITY
MARYLAND 21804
BOUNDS FUNERAL HOME, 705 E. MAIN ST., SALISBURY | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
IMMEDIATE CAUSE (Final disease or condition resulting in death) → PNEUMONIA
DUE TO (OR AS A CONSEQUENCE OF):
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. NEUROLYPTIC MAUGNANT SYNDROME
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.
DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA
OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation
<input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M | | 28c. INJURY AT WORK?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | 29a. CERTIFIER (Check only one)
<input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
<i>Edwin Castaneda</i> | | | | 29c. LICENSE NUMBER
246257 | | 29d. DATE SIGNED (Month, Day, Year)
5/12/96 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
EDWIN CASTANEDA SUITE 103 314 FRANKLIN AVE. BERLIN MD 21811 | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
MAY 13 1996 | | | | 32. REGISTRAR'S SIGNATURE
<i>John Davidson Radell</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene
Certificate of Death

96 15781

Reg. No.

| | | | | | | | | | |
|---|---|--|--|---|---|--|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
JAMES RAUSCH | | | | 2. Date of Death
Month Day Year
APRIL 23, 1996 | | 3. Time of Death
1129AM | | |
| | 4a. Facility Name (If not institution, give street and number)
PRINCE GEORGES HOSPITAL CENTER | | | | 4b. City, Town, or Location of Death
CHEVERLY | | 4c. County of Death
PRINCE GEORGES | | |
| Funeral
Director | 5. Social Security Number
577980244 | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday)
22 Yrs. | | 8. Date of Birth (Month, Day, Year)
May 25, 1973 | | |
| | 9. Birthplace (State or Foreign Country)
Wash. D.C. | | 10a. State
D.C. | | 10b. County
Washington | | 10c. City, Town or Location
Washington | | |
| 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 10e. Street and Number
2101 M St., N.E. #4 | | 10f. Zip Code
20002 | | 10g. Citizen of What Country?
United States | | | |
| 11. Marital Status
<input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No)
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: Black | | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (1-4or 5+) College (1-4or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
clerk | | 16b. Kind of Business/Industry
PRIVATE | | | | | |
| 17. Father's Name (First, Middle, Last)
James Rausch Sr. | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Phyllis Swann | | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
James Raush Sr./Father | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1606 C St., N.E. Wash. D.C. | | | | | |
| 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Harmony Mem. Park | | 20c. Date
5-1-96 | | 20d. Location - City or Town, State
Landover, Md. | | | |
| 21. Signature of Funeral Service Licensee
 | | 22. Name and Address of Facility
Hoffman Funeral Service
1425 Maryland Ave., N.E. | | | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
e. Gunshot Wound of Head
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of): | | | | | | | | Approximate Interval Between Onset and Death | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | |
| | | | | | | 24a. Was an autopsy performed?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | |
| | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | |
| 25. Was case referred to medical examiner?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. Manner of Death
<input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input checked="" type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day, Year)
4/23/96 | | 28b. Time of Injury
10 27 M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | |
| | | 28d. Describe how injury occurred
subject shot | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
motel | | 28f. Location (Street and Number or Rural Route Number, City or Town, State)
75 Hampton Pk Blvd Forestville, Md 20743 | | | |
| 29a. Certifier (Check only one)
<input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier
 | | 29c. License number
O.C.M.E. | | 29d. Date signed (Month, Day, Year)
APRIL 24, 1996 | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Dennis J. Chute MD 111 Penn Street, Baltimore, Maryland 21201 | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
MAY 07 1996 | | 32. Registrar's Signature
 | | | | | | | |

Baltimore, Maryland 21215-0020
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

State Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 15782

Certificate of Death

Reg. No.

| | | | | | | | | |
|--|---|---|--|--|---|--|---|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
JOSEPH ROBINSON | | | | 2. Date of Death
Month APRIL Day 11 Year 1996 | | 3. Time of Death
00:57 AM | |
| | 4a. Facility Name (If not institution, give street and number)
SOUTHERN MARYLAND HOSPITAL | | | | 4b. City, Town, or Location of Death
CHINTON | | 4c. County of Death
PRINCE GEORGE | |
| Funeral
Director | 5. Social Security Number
578-03-8792 | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday)
88 Yrs. | | 8. Date of Birth (Month, Day, Year)
12/4/1908 | |
| | 9. Birthplace (State or Foreign Country)
West | | 10a. Usual Residence of Decedent
10a. State
MD | | 10b. County
Prince Georges | | 10c. City, Town or Location
Ft. Washington | |
| 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 10e. Street and Number
7824 Klovstad Drive | | 10f. Zip Code
20744 | | 10g. Citizen of What Country?
USA | | |
| 11. Marital Status
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: WHITE | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 2 Years | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Building Contractor | | 16b. Kind of Business/Industry
Self Employed | | | | |
| 17. Father's Name (First, Middle, Last)
Joe Lee Robinson | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Emma Fitzpatrick | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
Ruth P. Robinson | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
7824 Klovstad Dr., Ft. Washington, MD. 20744 | | | | |
| 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input checked="" type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Georgetown Med. Sch. | | 20c. Date
4/29/96 | | 20d. Location - City or Town, State
Washington, DC. | | |
| 21. Signature of Funeral Service Licensee
 | | | | 22. Name and Address of Facility
Austin Royater Funeral Home
3605 14th St. N.W., Wash, DC. 20010 | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

a. Encephalopathy
Due to (or as a consequence of):

b. Chronic obstructive Pulmonary disease
Due to (or as a consequence of):

c.
Due to (or as a consequence of):

d.
Due to (or as a consequence of): | | | | | | | | |
| 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | | | | |
| 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Atrial fibrillation
Coronary artery disease
Cerebrovascular Accident | | | | | | | | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death
<input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | |
| 29b. Signature and title of certifier
 | | | | 29c. License number
345435 | | 29d. Date signed (Month, Day, Year)
4/11/96 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
VALLEY MATTHEW MD SOUTHERN MARYLAND HOSPITAL | | | | | | | | |
| 31. Date filed (Month, Day, Year)
MAY 08 1996 | | 32. Registrar's Signature
 | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 15783

Certificate of Death

Reg. No.

| | | | | | | | | |
|--|--|--|---|--|--|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
<u>Helen L. Smith</u> | | | | 2. Date of Death
Month <u>May</u> Day <u>03</u> Year <u>1996</u> | | 3. Time of Death
<u>1 AM</u> | |
| | 4a. Facility Name (If not institution, give street and number)
<u>Lorien Nursing and Rehab Center</u> | | | | 4b. City, Town, or Location of Death
<u>COLUMBIA</u> | | 4c. County of Death
<u>HOWARD</u> | |
| Funeral
Director | 5. Social Security Number
<u>220-20-3517</u> | | 6. Sex
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday)
<u>67</u> Yrs. | | 8. Date of Birth (Month, Day, Year)
<u>JUNE 8 1928</u> | |
| | 9. Birthplace (State or Foreign Country)
<u>SOUTH CAROLINA</u> | | 10e. State
<u>MARYLAND</u> | | 10b. County
<u>CITY</u> | | 10c. City, Town or Location
<u>BALTIMORE</u> | |
| To Be Completed by Funeral Director | 10d. Inside City Limits
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 10e. Street and Number
<u>2118 W. SARATOGA STREET</u> | | 10f. Zip Code
<u>21223</u> | | 10g. Citizen of What Country?
<u>US</u> | |
| | 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: <u>BLACK</u> | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) <u>12th</u> College (1-4 or 5+) <u>0</u> | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
<u>FACTORY EMPLOYEE</u> | | 16b. Kind of Business/Industry
<u>CAMP MANUFACTURING CO.</u> | | | |
| | 17. Father's Name (First, Middle, Last)
<u>WALLACE McCROREY</u> | | | | 18. Mother's Name (First, Middle, Maiden Surname)
<u>ELSIE SMITH</u> | | | |
| | 19a. Informant's Name/Relationship (Type, Print)
<u>BRENDA WOODSON (DAUGHTER)</u> | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
<u>6417 SPICEWIND CT. COLUMBIA, MD. 21045</u> | | | |
| | 20a. Method of Disposition
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
<u>MARYLAND VETERAN CEMETERY 5/8/96 CROWNSVILLE, MD.</u> | | 20c. Location - City or Town, State | | | |
| | 21. Signature of Funeral Service Licensee
<u>Larry D. Reese</u> | | | | 22. Name and Address of Facility
<u>WM. REESE & SONS MORTUARY, P.A.
821 WEST ST. ANNAPOLIS, MD. 21401</u> | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
<u>Cerebrovascular Accident</u>
Due to (or as a consequence of):

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

Due to (or as a consequence of):

Due to (or as a consequence of): | | | | | | | |
| | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | | | | | |
| | 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | | |
| Physician
/Medical
Examiner | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
<u>Seizure disorder; Senile dementia Alzheimers</u>
<u>type</u> | | | | | | | |
| | 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | |
| | 26. Place of Death (Check only one)
Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | |
| | 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide
5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
<u>M</u> | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| | 28d. Describe how injury occurred | | | | 28e. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| | 29a. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | |
| | 29b. Signature and title of certifier
<u>Steve Geller MD</u> | | | | 29c. License number
<u>d 34613</u> | | 29d. Date signed (Month, Day, Year)
<u>May 7, 1996</u> | |
| | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
<u>Steven Geller MD 9501 Old Annapolis Rd, Ellicott City MD 21042</u> | | | | | | | |
| | 31. Date filed (Month, Day, Year)
<u>MAY 10 1996</u> | | 32. Registrar's Signature
<u>Julia Davidson-Rendall</u> | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 15784

Certificate of Death

Reg. No.

| | | | | | | | | | | |
|--|---|--|---|--------------------------------------|--|--|--|--|---|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
JUNE SNOWDEN | | | | | 2. Date of Death
Month Day Year
MAY 7 1996 | | | 3. Time of Death
6:30 pm | |
| | 4a. Facility Name (If not institution, give street and number)
1452 TYLERR AVENUE | | | | | 4b. City, Town, or Location of Death
ANNAPOLIS | | | 4c. County of Death
ANNE ARUNDEL | |
| Funeral
Director | 5. Social Security Number
217-76-5686 | | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday)
37 Yrs. | | 8. Date of Birth (Month, Day, Year)
JUNE 18 1958 | | 9. Birthplace (State or Foreign Country)
MARYLAND | |
| | Usual Residence of Decedent | | | | | | | | | |
| To Be Completed by Funeral Director | 10a. State
MARYLAND | | 10b. County
ANNE ARUNDEL | | 10c. City, Town or Location
ANNAPOLIS | | | 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| | 10e. Street and Number
1452 TYLER AVENUE | | | | 10f. Zip Code
21403 | | | 10g. Citizen of What Country?
US | | |
| | 11. Marital Status
<input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc.
Specify: BLACK | | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 8th College (1-4 or 5+) 0 | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
NONE | | | 16b. Kind of Business/Industry
NONE | | |
| | 17. Father's Name (First, Middle, Last)
JAMES E. SNOWDEN, JR. | | | | 18. Mother's Name (First, Middle, Maiden Surname)
BARBARA JEAN SIMMS | | | | | |
| | 19a. Informant's Name/Relationship (Type, Print)
BARBARA J. SNOWDEN (MOTHER) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1452 TYLER AVE. ANNAPOLIS, MD. 21403 | | | | | |
| | 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
ANNAPOLIS MEM. GARDENS | | 20c. Date
5/10/96 | | 20d. Location - City or Town, State
ANNAPOLIS, MD. | | | |
| | 21. Signature of Funeral Service Licensee
Harry D. Reese | | | | 22. Name and Address of Facility
WM. REESE & SONS MORTUARY, P.A.
821 WEST ST. ANNAPOLIS, MD. 21401 | | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. Metastatic pancreatic cancer
Due to (or as a consequence of):

b.
Due to (or as a consequence of):

c.
Due to (or as a consequence of):

d. | | | | | | | | | |
| | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown

24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | | | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | | | |
| 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input type="checkbox"/> No | | 28d. Describe how injury occurred | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier
Ch. C. May, MD | | 29c. License number
D44465 | | 29d. Date signed (Month, Day, Year)
05/09/96 | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Annapolis Medical Specialists, 900 Bortgate Road, Suite 300, Annapolis, MD 21401 | | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
MAY 13 1996 | | 32. Registrar's Signature
J. Davidson-Randall | | | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 15785

Certificate of Death

Reg. No.

| | | | | | | | | |
|---|---|---|---|--|--|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Robert Vincent St John | | | | 2. Date of Death
Month Day Year
May 5 1996 | | 3. Time of Death
2:55 A.M. | |
| | 4a. Facility Name (If not institution, give street and number)
1805 Plymouth Court | | | | 4b. City, Town, or Location of Death
Bowie | | 4c. County of Death
Prince George's | |
| Funeral
Director | 5. Social Security Number
216 50 7938 | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)
78 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth (Month, Day, Year)
Feb. 15, 1918 | | 9. Birthplace (State or Foreign Country)
Nebraska |
| | Usual Residence of Decedent | | | | | | | |
| 10a. State
Maryland | | 10b. County
Prince George's | | 10c. City, Town or Location
Bowie | | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | |
| 10e. Street and Number
1805 Plymouth Court | | | | 10f. Zip Code
20716 | | 10g. Citizen of What Country?
United States | | |
| 11. Marital Status
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
If Yes, Give Year or Dates: WWII | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: White | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 2 College (1-4or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Route Salesman | | 16b. Kind of Business/Industry
Food | | |
| 17. Father's Name (First, Middle, Last)
Unavailable | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Mira S. Langford | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
Michelle Flock | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1805 Plymouth Court Bowie Maryland 20716 | | | | |
| 20a. Method of Disposition
<input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Grandview Cemetery 5/9/96 | | Data | | 20c. Location - City or Town, State
Taswell Virginia | | |
| 21. Signature of Funeral Service Licensee
Robert E. Evans Pres. | | | | 22. Name and Address of Facility
Robert E. Evans Funeral Home, P.A.
16000 Annapolis Rd. Bowie Md. 20715 | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. Cause of the Injury
Due to (or as a consequence of):
b. Small cell cancer
Due to (or as a consequence of):
c. 2 metastases
Due to (or as a consequence of):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last | | | | | | | | Approximate Interval Between Onset and Death |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | |
| | | | | | | 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | |
| | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | |
| 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation
<input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined
<input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | |
| | | 28d. Describe how Injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | |
| 29b. Signature and title of certifier
[Signature] | | | | 29c. License number
D04483 | | 29d. Date signed (Month, Day, Year)
5.6.96 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Til Bergeman 115 Centerway rd. Greenbelt Md. | | | | | | | | |
| 31. Date filed (Month, Day, Year)
MAY 10 1996 | | | | 32. Registrar's Signature
[Signature] | | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 15786

Certificate of Death

Reg. No.

| | | | | | | | | | | | | |
|---|---|---|---|--|--|--|--|---|---|--|---|---|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
KAROLYN SHEDRICK M | | | | 2. Date of Death
Month 4 - Day 19 - Year 96 | | 3. Time of Death
1:00pm | | | | | |
| | 4a. Facility Name (If not institution, give street and number)
HYATTSVILLE MANOR | | | | 4b. City, Town, or Location of Death
HYATTSVILLE | | 4c. County of Death
PRINCE GEORGES | | | | | |
| Funeral
Director | 5. Social Security Number
237-82-1024 | | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)
48 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth
(Month, Day, Year)
08-11-47 | 9. Birthplace (State or Foreign Country)
U.S.A. | | | | |
| | Usual Residence of Decedent | | | | | | | | | | | |
| To Be Completed by Funeral Director | 10a. State
MD. | | 10b. County
PRINCE GEORGES | | 10c. City, Town or Location
HYATTSVILLE | | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | | |
| | 10e. Street and Number
3500 RIGGS ROAD | | | | 10f. Zip Code
20783 | | 10g. Citizen of What Country?
UNITED STATES | | | | | |
| | 11. Marital Status
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: WHITE | | | | | |
| | 15. Decedent's Education
(Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (1-4or 5+) | | 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)
Domestic | | 16b. Kind of Business/Industry
PRIVATE | | | | | | | |
| | 17. Father's Name (First, Middle, Last)
CHARLES J. SUTTON | | | | 18. Mother's Name (First, Middle, Maiden Surname)
HAZEL O. OWEN | | | | | | | |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print)
CALPERNIA C. MILLER | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1242 FLORIDA AVE., NE WASH., DC 20002 | | | | | | | |
| | 20a. Method of Disposition
<input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
NO. VIRGINIA CREM. | | Date
4-20-96 | | 20c. Location - City or Town, State
ARLINGTON, VA | | | | | |
| | 21. Signature of Funeral Service Licensee
Sharon Johnson-Lalley | | | | 22. Name and Address of Facility
CAPITOL MORTUARY
1425 MARYLAND AVE., NE WASH., DC 20002 | | | | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | | | | | |
| | <table border="0"> <tr> <td rowspan="4">Immediate Cause (Final disease or condition resulting in death)</td> <td>a. AIDS
Due to (or as a consequence of):</td> </tr> <tr> <td>b. TOXOPLASMOSIS
Due to (or as a consequence of):</td> </tr> <tr> <td>c. CARDIOPULMONARY FAILURE
Due to (or as a consequence of):</td> </tr> <tr> <td>d.</td> </tr> </table> | | | | | | | | Immediate Cause (Final disease or condition resulting in death) | a. AIDS
Due to (or as a consequence of): | b. TOXOPLASMOSIS
Due to (or as a consequence of): | c. CARDIOPULMONARY FAILURE
Due to (or as a consequence of): |
| Immediate Cause (Final disease or condition resulting in death) | a. AIDS
Due to (or as a consequence of): | | | | | | | | | | | |
| | b. TOXOPLASMOSIS
Due to (or as a consequence of): | | | | | | | | | | | |
| | c. CARDIOPULMONARY FAILURE
Due to (or as a consequence of): | | | | | | | | | | | |
| | d. | | | | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
ANEMIA | | | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | | |
| | | | | | | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | |
| | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | |
| | | 28d. Describe how injury occurred | | 28e. Piece of injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier
Robert D. Skipworth MD | | 29c. License number
(Maryland) D28906 | | 29d. Date signed (Month, Day, Year)
4-19-96 | | | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Robert D. Skipworth MD 585 MAIN STREET LAUREL MARYLAND 20707 | | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
MAY 07 1996 | | | | 32. Registrar's Signature
John Anderson-Randall | | | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

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Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 15787

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Snoden Archibald STUBBS

2. Date of Death

May 3, 1996

3. Time of Death

11:45 PM

4a. Facility Name (If not institution, give street and number)

Doctors' Community Hospital

4b. City, Town, or Location of Death

Lanham

4c. County of Death

Prince George's

Funeral
Director

5. Social Security Number

579-32-8119

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

75 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

June 1, 1920

9. Birthplace (State or Foreign Country)

North Carolina

Usual Residence of Decedent

10a. State

MD

10b. County

Prince George's

10c. City, Town or Location

Hyattsville

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

6807 Fairwood Road

10f. Zip Code

20784

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married

3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No 1943

If Yes, Give Year or Dates: 1939-

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

9

Collage (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Building Engineer

16b. Kind of Business/Industry

Metro

17. Father's Name (First, Middle, Last)

Robert Livingston Stubbs

18. Mother's Name (First, Middle, Maiden Summa)

Nellie Waters

19a. Informant's Name/Relationship (Type, Print)

Dennis J. Stubbs / son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

17409 Clagett Landing Road, Upper Marlboro, MD 20772

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State

4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Gate of Heaven Cem. 5/07/1996

Date

20c. Location - City or Town, State

Silver Spring, Maryland

21. Signature of Funeral Service Licensee

Henry S. Ford

22. Name and Address of Facility

Francis Gasch's Sons Funeral Home, P.A.

4739 Baltimore Avenue, Hyattsville, Maryland

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

CONGESTIVE CARDIAC FAILURE

Approximate Interval Between Onset and Death

one year

a. Due to (or as a consequence of):

DILATED CONGESTIVE CARDIOMYOPATHY 5 years

b. Due to (or as a consequence of):

CORONARY ARTERY DISEASE 5 years

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

DIABETES MELLITUS

RENAL FAILURE.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient

2 ☐ ER/Outpatient

3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural

2 ☐ Accident

3 ☐ Suicide

4 ☐ Homicide

5 ☐ Pending investigation

6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Medical Examiner

2 ☐ Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

A. Rabin

29c. License number

D22910

29d. Date signed (Month, Day, Year)

May 4th 1996

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ASIF S. QADRI, 4700 BERWYN HOUSE RD, COLLEGE PK, MD 20740

31. Date filed (Month, Day, Year)

MAY 07 1996

32. Registrar's Signature

John R. ...

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 15788

Certificate of Death

Reg. No.

| | | | | | | | | | |
|--|--|---|---|--|---|--|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
<i>Roger C. Simmons III</i> | | | | 2. Date of Death
Month <i>5</i> Day <i>4</i> Year <i>96</i> | | 3. Time of Death
<i>10:25 AM</i> | | |
| | 4a. Facility Name (If not institution, give street and number)
<i>Hyattsville Healthcare Center</i> | | | | 4b. City, Town, or Location of Death
<i>Hyattsville</i> | | 4c. County of Death
<i>Prince George's</i> | | |
| Funeral
Director | 5. Social Security Number
<i>579 97 8009</i> | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)
<i>34</i> Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth (Month, Day, Year)
<i>10-4-61</i> | 9. Birthplace (State or Foreign Country)
<i>Washington DC</i> | |
| | Usual Residence of Decedent | | | | | | | | |
| To Be Completed by Funeral Director | 10a. State
<i>MD</i> | 10b. County
<i>Anne Arundel</i> | | 10c. City, Town or Location
<i>Annapolis</i> | | | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | |
| | 10e. Street and Number
<i>623 Bywater Road</i> | | | 10f. Zip Code
<i>21401</i> | | 10g. Citizen of What Country?
<i>USA</i> | | | |
| | 11. Marital Status
<input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: <i>Black</i> | | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) <i>11th</i> College (1-4or 5+) <i></i> | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
<i>Warehouseman</i> | | | 16b. Kind of Business/Industry
<i>Private</i> | | | |
| | 17. Father's Name (First, Middle, Last)
<i>Roger C. Simmons, Jr.</i> | | | | 18. Mother's Name (First, Middle, Maiden Surname)
<i>Mary Barlow</i> | | | | |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print)
<i>Roger Simmons Jr./Father</i> | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
<i>11707 Mordente Drive, Clinton, MD 20735</i> | | | | |
| | 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
<i>Harmony Memorial Pk</i> | | Date
<i>5/9/96</i> | | 20c. Location - City or Town, State
<i>Landover, MD</i> | | |
| | 21. Signature of Funeral Service Licensee
<i>James C. Busch - Tonic</i> | | | | 22. Name and Address of Facility
<i>J. B. Jenkins Funeral Home
7474 Landover Rd, Landover, MD 20785</i> | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | | |
| | Immediate Cause (Final disease or condition resulting in death)
e. <i>AIDS</i>
Due to (or as a consequence of):
b. <i>Cytomegalovirus Disease</i>
Due to (or as a consequence of):
c. <i>Hepatitis</i>
Due to (or as a consequence of):
d. <i>Cardiopulmonary Failure</i> | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
<i>Leukopenia</i>
<i>Anemia</i>
<i>Pneumonia</i> | | | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | | |
| 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No | | | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accidental <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
<i>M</i> | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how Injury occurred | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier
<i>Robert D Skipworth MD</i> | | | | | | | |
| 29c. License number
<i>(Maryland) D28906</i> | | 29d. Date signed (Month, Day, Year)
<i>5/4/96</i> | | | | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
<i>Robert Skipworth, M.D. 585 Main Street, Suite 143, Laurel, MD 20707</i> | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
<i>MAY 09 1996</i> | | 32. Registrar's Signature
<i>John D. ...</i> | | | | | | | |

Baltimore, Maryland 21215-0020

permitted. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

(3)

State
Registrar

1. The first part of the report is a general introduction to the subject of the study. It discusses the importance of the problem and the objectives of the research.

2. The second part of the report is a detailed description of the methods used in the study. It includes a discussion of the experimental design, the data collection procedures, and the statistical analysis techniques.

3. The third part of the report is a presentation of the results of the study. It includes a discussion of the findings, the interpretation of the data, and the conclusions drawn from the research.

4. The fourth part of the report is a discussion of the implications of the study. It includes a discussion of the theoretical and practical significance of the findings, and suggestions for further research.

5. The fifth part of the report is a summary of the study. It includes a brief overview of the main findings and conclusions, and a statement of the author's acknowledgments.

6. The sixth part of the report is a list of references. It includes a list of the books, articles, and other sources used in the study.

7. The seventh part of the report is an appendix. It includes a list of the tables, figures, and other supplementary material used in the study.

8. The eighth part of the report is a conclusion. It includes a final statement of the author's findings and conclusions, and a statement of the author's thanks.

9. The ninth part of the report is a list of the author's publications. It includes a list of the books, articles, and other sources published by the author.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

96 15789

Reg. No.

| | | | | | | | | | | | | | | | |
|--|---|----------------------------------|---|---|--|--|--|--|---|---|--|--------------------------------------|--|---|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
DORIS L. STONEY | | | | | | 2. Date of Death
Month Day Year
May 1, 1996 | | 3. Time of Death
3:15 a.m. | | | | | | |
| | 4a. Facility Name (If not institution, give street and number)
ALLEGIS HEALTH CARE CENTER | | | | | | 4b. City, Town, or Location of Death
Bethesda | | 4c. County of Death
Montgomery | | | | | | |
| Funeral
Director | 5. Social Security Number
579-30-4071 | | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday)
73 Yrs. | | 8. Date of Birth (Month, Day, Year)
Dec. 5, 1922 | | 9. Birthplace (State or Foreign Country)
Greensboro, N.C. | | | | | | |
| | Usual Residence of Decedent | | | | | | | | | | | | | | |
| 10a. State
District of Columbia | | 10b. County
Washington | | 10c. City, Town or Location
Washington | | | | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | |
| 10e. Street and Number
920 6th Street, N. E. | | | 10f. Zip Code
20002 | | | 10g. Citizen of What Country?
United States | | | | | | | | | |
| 11. Marital Status
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc.
Specify:
African American | | | | | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) | | | | 15a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Retired Computer Specialist | | | | 16b. Kind of Business/Industry
U. S. Government | | | | | | | |
| 17. Father's Name (First, Middle, Last)
James Charles Graham | | | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Myrtle Nicholas | | | | | | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
Joseph Stoney - Husband | | | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
5805 42nd Avenue, #624, Hyattsville, MD 20781 | | | | | | | | | |
| 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Harmony Memorial Park | | 20c. Date
5/8/96 | | 20d. Location - City or Town, State
Landover, MD | | | | | | | |
| 21. Signature of Funeral Service Licensee
John T. Stewart III | | | | | | 22. Name and Address of Facility
STEWART FUNERAL HOME, Inc.
4001 Benning Road, N.E., Washington, D. C. | | | | | | | | | |
| 23. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. Congestive Heart Failure
Dua to (or as a consequence of):

b.
Dua to (or as a consequence of):

c.
Dua to (or as a consequence of):

d. | | | | | | | | | | Approximate Interval Between Onset and Death
month | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Prostate | | | | | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | | | |
| | | | | | | | | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No | | | | | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation
<input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined
<input type="checkbox"/> Suicida <input type="checkbox"/> Homicida | | | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how Injury occurred | | | | | |
| | | | | 28a. Place of injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | | | 29b. Signature and title of certifier
John T. Stewart III | | 29c. License number
020516 | | 29d. Date signed (Month, Day, Year)
5/11/96 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
9410 Old Georgetown Rd Bethesda Md 20814 | | | | | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
MAY 09 1996 | | | | 32. Registrar's Signature
John T. Stewart III | | | | | | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 15790

Certificate of Death

Reg. No.

| | | | | | | | | | | |
|--|--|--|---|--|--|--|--|---|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
William Stephens | | | | 2. Date of Death
Month May Day 7 Year 1996 | | | | 3. Time of Death
1:32 AM | |
| | 4a. Facility Name (If not institution, give street and number)
Salisbury Center; Genesis Eldercare | | | | 4b. City, Town, or Location of Death
Salisbury, Md. | | | | 4c. County of Death
Wicomico | |
| Funeral
Director | 5. Social Security Number
214-10-8408 | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday)
85 Yrs. | | 8. Date of Birth (Month, Day, Year)
March 5, 1911 | | 9. Birthplace (State or Foreign Country)
Delaware | |
| | Usual Residence of Decedent | | | | | | | | | |
| To Be Completed by Funeral Director | 10a. State
Maryland | | 10b. County
Wicomico | | 10c. City, Town or Location
Salisbury | | | | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | |
| | 10e. Street and Number
808 Brown St. | | | | 10f. Zip Code
21801 | | 10g. Citizen of What Country?
USA | | | |
| | 11. Marital Status
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc.
Specify: White | | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 5 College (1-4 or 5+) 0 | | | | 16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Antique Dealer | | | 16b. Kind of Business/Industry
Antiques | | |
| | 17. Father's Name (First, Middle, Last)
Albert Stephens | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Viola Baker | | | | | |
| | 19. Informant's Name/Relationship (Type, Print)
Helen D. Insley | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
P.O. Box 11, Mardela Springs, MD 21837 | | | | | |
| | 20e. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Melson's Cemetery | | 20c. Location - City or Town, State
5/9/96 Delmar, MD | | | |
| | 21. Signature of Funeral Service Licensee
 | | | | 22. Name and Address of Facility
Holloway Funeral Home
501 Snow Hill Rd., Salisbury, MD 21804 | | | | | |
| | 23a. Pertinent disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Metastatic Cancer of unknown primary source
Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of): | | | | | | | | | |
| | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | | | | | | | |
| Physician
/Medical
Examiner | 23a. Immediate Cause (Final disease or condition resulting in death)

END STAGE RENAL FAILURE | | | | | | | | | |
| | 23b. Sequence of conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last | | | | | | | | | |
| | 23c. Pertinent disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

END STAGE RENAL FAILURE | | | | | | | | | |
| | 23d. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | | | | | | | |
| To Be Completed by Physician/Medical Examiner | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
END STAGE RENAL FAILURE | | | | | | | | | |
| | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | | | | | | | |
| | 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | | | |
| | 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | | | |
| | 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | | | |
| | 26. Place of Death (Check only one)
Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | | | |
| | 27. Manner of Death
1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation
2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined
3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how Injury occurred | |
| | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| | 29e. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | | |
| | 29b. Signature and title of certifier
 | | | | 29c. License number
D-39813 | | 29d. Date signed (Month, Day, Year)
5/7/96 | | | |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)
Dr. Michael Atkins, M.D. 1104 HEALTHWAY DR., SALISBURY, MD. 21804 | | | | | | | | | | |
| State
Registrar | 31. Date filed (Month, Day, Year)
MAY 09 1996 | | | | 32. Registrar's Signature
 | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 23b-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

96 15791

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|---|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
EVA VIRGINIA SENEY | | | | 2. DATE OF DEATH
MONTH DAY YEAR
May 3, 1996 | | 3. TIME OF DEATH
1:30 P.M. | |
| 4. SOCIAL SECURITY NUMBER
212-10-0194 | | 5. SEX
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
85 YRS. | | 7. DATE OF BIRTH (Month, Day, Year)
September 16, 1910 | |
| 9a. FACILITY NAME (If not institution, give street and number)
109 N. Division St. | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
Fruitland | | 9c. COUNTY OF DEATH
Wicomico | |
| 10a. STATE
Maryland | | 10b. COUNTY
Wicomico | | 10c. CITY, TOWN OR LOCATION
Fruitland | | 10d. INSIDE CITY LIMITS?
<input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER
109 N. Division St. | | | | 10f. ZIP CODE
21826 | | 10g. CITIZEN OF WHAT COUNTRY?
USA | |
| 11. MARITAL STATUS
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify: White | |
| 15. DECEDENT'S EDUCATION
(Specify only highest grade completed)
Elementary/Secondary (0-12) 6 College (1-4 or 5+) 0 | | 18a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.)
Supervisor | | 16b. KIND OF BUSINESS/INDUSTRY
C & P Telephone Co. | | | |
| 17. FATHER'S NAME (First, Middle, Last)
John B. Adkins | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Cordelia Florence Ennis | | | |
| 19a. INFORMANT'S NAME (Type/Print)
Charlotte Cullen | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
36223 Old Ocean City Rd., Willards, MD 21874 | | | |
| 20a. METHOD OF DISPOSITION
<input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
St. John's Cemetery 5/7 | | 20c. LOCATION — City or Town, State
Fruitland, MD | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
<i>John A. Adkins</i> | | | | 22. NAME AND ADDRESS OF FACILITY
Holloway Funeral Home
501 Snow Hill Rd., Salisbury, MD 21804 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>chronic obstructive lung disease</i>
DUE TO (OR AS A CONSEQUENCE OF):
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST {
b. DUE TO (OR AS A CONSEQUENCE OF):
c. DUE TO (OR AS A CONSEQUENCE OF):
d. | | | | | | Approximate Interval Between Onset and Death
1987 | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 24a. WAS AN AUTOPSY PERFORMED?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation
2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 6 <input type="checkbox"/> Could not be determined
4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 28c. INJURY AT WORK?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| | | 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. CERTIFIER (Check only one)
1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. SIGNATURE AND TITLE OF CERTIFIER
<i>W.B. Horner MD</i> | | 29c. LICENSE NUMBER
D13053 | | 29d. DATE SIGNED (Month, Day, Year)
5/7/96 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
W. BENJAMIN HORNER 100 POWER ST. SALISBURY, MD. 21801 | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
MAY 07 1996 | | 32. REGISTRAR'S SIGNATURE
<i>John A. Adkins</i> | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 6876 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL DR. ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 15792

Certificate of Death

Reg. No.

| | | | | | | | | |
|---|---|---|--|---|--|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Daryl Tucker | | | | 2. Date of Death
Month Day Year
May 7, 1996 | | 3. Time of Death
9:30 P.M. | |
| | 4a. Facility Name (If not institution, give street and number)
7535 Brown Bridge Rd. | | | | 4b. City, Town, or Location of Death
Highland | | 4c. County of Death
Howard | |
| Funeral
Director | 5. Social Security Number
215 68 7857 | | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday)
39 Yrs. | | 8. Date of Birth (Month, Day, Year)
Nov. 19, 1956 | |
| | 9. Birthplace (State or Foreign Country)
Maryland | | 10a. State
Maryland | | 10b. County
Montgomery | | 10c. City, Town or Location
Silver Spring | |
| To Be Completed by Funeral Director | 10e. Street and Number
2405 Normandy Sq. Place | | 10f. Zip Code
20905 | | 10g. Citizen of What Country?
United States | | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | |
| | 11. Marital Status
<input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: White | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Hair Stylist | | 16b. Kind of Business/Industry
Salon | | | |
| | 17. Father's Name (First, Middle, Last)
Robert A. Zupko | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Sue Ogens | | | |
| | 19a. Informant's Name/Relationship (Type, Print)
Robert A. Zupko Father | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1742 Albermarle Drive Crofton Maryland 21114 | | | |
| | 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Lakemont Memorial Gardens | | 20c. Location - City or Town, State
5/9/96 Davidsonville Md. | | 21. Signature of Funeral Service Licensee
Robert E. Evans Pres | |
| | 22. Name and Address of Facility
Robert E. Evans Funeral Home, P.A. | | 22. Name and Address of Facility
16000 Annapolis Rd. Bowie Maryland 20715 | | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
Respiratory Failure
Due to (or as a consequence of):
Pseudomonas Pneumonia
Due to (or as a consequence of):
CMV Pneumonitis
Due to (or as a consequence of):
AIDS | | | |
| | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | |
| | 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA
Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation
<input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined
<input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | | |
| | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier
Princy K. Kumar | | 29c. License number
17469 | | 29d. Date signed (Month, Day, Year)
5/8/96 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Georgetown University Medical Center, Washington D.C. 20007 | | 31. Date filed (Month, Day, Year)
MAY 10 1996 | | 32. Registrar's Signature
John H. ... | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

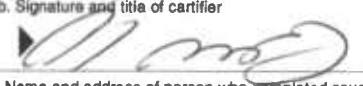
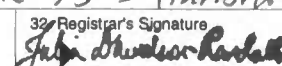
96 15793

Certificate of Death

Reg. No.

| | | | | | | | | | | | | |
|--|--|--|---|--|---|--|--|---|--|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Gene Franklin Tyler | | | | | | 2. Date of Death
Month Day Year
April 30 1996 | | 3. Time of Death
8:20 PM | | | |
| | 4a. Facility Name (If not institution, give street and number)
7223 Marywood Street | | | | | | 4b. City, Town, or Location of Death
Hyattsville | | 4c. County of Death
Prince George's | | | |
| Funeral
Director | 5. Social Security Number
255 12 1274 | | 6. Sex
1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 7. Age (In yrs. last birthday)
79 | | 8. Date of Birth (Month, Day, Year)
Aug. 8, 1916 | | 9. Birthplace (State or Foreign Country)
Georgia | | | |
| | Usual Residence of Decedent | | | | | | | | | | | |
| To Be Completed by Funeral Director | 10a. State
Maryland | | 10b. County
Prince George's | | 10c. City, Town or Location
Hyattsville | | | | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | |
| | 10e. Street and Number
7223 Marywood Street | | | | 10f. Zip Code
20784 | | 10g. Citizen of What Country?
United States | | | | | |
| | 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
If Yes, Give Year or Dates: 43-46 | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc.
Specify: White | | | | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 10 College (1-4or 5+) 10 | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Production Manager | | | 16b. Kind of Business/Industry
Printing Company | | | | |
| | 17. Father's Name (First, Middle, Last)
Thomas Franklin Tyler | | | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Sally Ida Whittle | | | | | |
| | 19a. Informant's Name/Relationship (Type, Print)
Violette Tyler | | | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
7223 Marywood Street Hyattsville Maryland 20784 | | | | | |
| | 20a. Method of Disposition
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Maryland Veterans Cemetery 5/6/96 | | 20c. Location - City or Town, State
Crownsville Md. | | | | | |
| | 21. Signature of Funeral Service Licensee
Robert E. Evans Pres | | | | 22. Name and Address of Facility
Robert E. Evans Funeral Home, P.A.
16000 Annapolis Rd. Bowie Maryland 20715 | | | | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. <u>Cardiopulmonary failure</u>
Due to (or as a consequence of):
b. <u>metastatic cancer</u>
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | | | | Approximate Interval Between Onset and Death
Several months | |
| | Physician
/Medical
Examiner | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown | | |
| | | | | | | | | 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | |
| | | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | |
| | | | | | | | | | | | | |
| Medical Certification: To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | | | |
| | 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation
2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined
3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. Date of injury (Month, Day Year) | | 28b. Time of injury
M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | | | |
| | | | 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) | | | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| | 29a. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | | | | |
| State Registrar | 29b. Signature and title of certifier
 M.D., Ph.D. | | | | 29c. License number
046093 | | 29d. Date signed (Month, Day, Year)
5/8/96 | | | | | |
| | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Redman Mastaghim 7305 Hanover pkwy, Greenbelt MD 20770 | | | | | | | | | | | |
| | 31. Date filed (Month, Day, Year)
MAY 08 1996 | | 32. Registrar's Signature
 | | | | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 15794

| | | | | | |
|--|--|--|---|--------------------------------|---|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Marjorie Tomco | | 2. Date of Death
Month May , Day 12 , Year 1996 | | 3. Time of Death
0544 |
| | 4a. Facility Name (If not institution, give street and number)
Calvert Memorial Hospital | | 4b. City, Town, or Location of Death
Prince Frederick | | 4c. County of Death
Calvert |
| Funeral
Director | 5. Social Security Number
577-52-9391 | 8. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)
58 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. |
| | Usual Residence of Decedent | | 8. Date of Birth (Month, Day, Year)
March 28, 1938 | | 9. Birthplace (State or Foreign Country)
Washington, D.C. |
| To Be Completed by Funeral Director | 10a. State
Maryland | 10b. County
Calvert | 10c. City, Town or Location
Lusby | | 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| | 10e. Street and Number
8335 Swallow Lane | | 10f. Zip Code
20657 | | 10g. Citizen of What Country?
USA |
| | 11. Marital Status
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - if Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 8 College (1-4 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Telephone Operator | | 14. Race - American Indian, Black, White, etc.
Specify: White |
| | 17. Father's Name (First, Middle, Last)
Raymond Saunders | | 18. Mother's Name (First, Middle, Maiden Surname)
Ethel Mulloy | | 16b. Kind of Business/Industry
Telecommunication |
| | 19a. Informant's Name/Relationship (Type, Print)
Raymond Tomco/Husband | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
8335 Swallow Lane Lusby, MD 20657 | | |
| | 20a. Method of Disposition
<input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Metropolitan Crematory | | 20c. Location - City or Town, State
5/13/96 Alexandria, VA |
| | 21. Signature of Funeral Service Licensee
Spencer E. Sewell | | 22. Name and Address of Facility
Sewell Funeral Home
1451 Dares Beach Rd. Prince Frederick, MD 20678 | | |
| | 23e. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | |
| | 23f. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
CHF, Diabetes Mellitus
Hepatic Abscess | | | | |
| Physician
/Medical
Examiner | 23a. Immediate Cause (Final disease or condition resulting in death)
Cardiac Arrest | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| | 23b. CAD. | | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| Medical Certification: To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | |
| | 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation
<input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined
<input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | 28a. Date of injury (Month, Day, Year) | | 28b. Time of injury
M |
| | 28c. Injury et Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | | |
| | 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | |
| | 29a. Certifier
(Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | |
| | 29b. Signature and title of certifier
Spencer E. Sewell | | 29c. License number
527189 | | 29d. Date signed (Month, Day, Year)
5/12/96 |
| | 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)
John R. Yousef, P.O. Box 1289 Waldorf, M.D. 20604-1289. | | | | |
| | 31. Date filed (Month, Day, Year)
MAY 14 1996 | | 32. Registrar's Signature
Davidson-Randall | | |
| | State Registrar | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 15795

Certificate of Death

Reg. No.

| | | | | | | | | | | | | |
|--|--|--|---|--|--|---|--|--|--|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
John Francis Toal | | | | | 2. Date of Death
Month Day Year
April 20, 1996 | | 3. Time of Death
2:43 P.M. | | | | |
| | 4a. Facility Name (If not institution, give street and number)
Malcolm Grow Medical Center | | | | | 4b. City, Town, or Location of Death
Camp Springs | | 4c. County of Death
Prince George's Co. | | | | |
| Funeral
Director | 5. Social Security Number
104-28-9962 | | 6. Sex
1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 7. Age (In yrs. last birthday)
59 Yrs. | | 8. Date of Birth (Month, Day, Year)
September 17, 1936 | | 9. Birthplace (State or Foreign Country)
Oyster Bay New York | | | |
| | Usual Residence of Decedent | | | | | | | | | | | |
| To Be Completed by Funeral Director | 10a. State
Maryland | | 10b. County
Prince George's County | | 10c. City, Town or Location
Upper Marlboro | | | | 10d. Inside City Limits
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | |
| | 10e. Street and Number
4709 Colonel Dent Court | | | | 10f. Zip Code
20772 | | 10g. Citizen of What Country?
United States of America | | | | | |
| | 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No
If Yes, Give Year or Dates: 1954-1974 | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc.
Specify: White | | | | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) College (1-4 or 5+) 4 | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Police Lieutenant | | | 16b. Kind of Business/Industry
United States Government | | | | | |
| | 17. Father's Name (First, Middle, Last)
Daniel J. Toal | | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Mary Ann McLaughlin | | | | | | |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print)
Nora P. Fanning (Niece) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
146 Morgan Place, North Arlington, New Jersey 07031 | | | | | | | |
| | 20a. Method of Disposition
1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Rosedale Crematory | | Date
April 27 1996 | | 20c. Location - City or Town, State
Orange, New Jersey | | | | | |
| | 21. Signature of Funeral Service Licensee #M00690
Howard A. Carson | | | | 22. Name and Address of Facility
Wilfred-Armitage Funeral Home
596 Belgrove Drive, Kearney, New Jersey 07032 | | | | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
Immediate Cause (Final disease or condition resulting in death)
e. Sepsis
Due to (or as a consequence of):
b. Myocardial Infarction
Due to (or as a consequence of):
c. Respiratory Failure
Due to (or as a consequence of):
d. Anuric Renal Failure | | | | | | | | | | Approximate Interval Between Onset and Death | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Hypoxemia | | | | | | | | | | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | |
| Medical Certification: To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify) | | | | | | | | | |
| | 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | | | |
| | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | | |
| | 29a. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | | |
| | 29b. Signature and title of certifier
TAVAF CPT Surgery Resident | | | | 29c. License number
MD-057638-L | | 29d. Date signed (Month, Day, Year)
April 20, 1996 | | | | | |
| State Registrar | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Houman Tavaf-Motamen, Capt. USAF, M.D. | | | | | 1050 West Perimeter Road, Suite C1-7
Andrews AFB, Camp Springs, Maryland | | | | | | |
| | 31. Date filed (Month, Day, Year)
MAY 09 1996 | | 32. Registrar's Signature
Julia Anderson-Rodell | | | | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Informant: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 15796

| | | | | | | | | | |
|--|---|---|--|--|---|--|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
ALICE BLANCHE VALLIERE | | | | 2. Date of Death
Month Day Year
MAY 13 1996 | | 3. Time of Death
1:05AM | | |
| | 4a. Facility Name (If not institution, give street and number)
908 E. STATE STREET | | | | 4b. City, Town, or Location of Death
DELMAR | | 4c. County of Death
WICOMICO | | |
| Funeral
Director | 5. Social Security Number
221-50-1249 | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)
102 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth
(Month, Day, Year)
AUG. 22, 1893 | 9. Birthplace (State or Foreign Country)
CANADA | | |
| | Usual Residence of Decedent | | | | | | | | |
| 10a. State
MD | | 10b. County
WICOMICO | | 10c. City, Town or Location
DELMAR | | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | |
| 10e. Street and Number
908 E. STATE STREET | | | | 10f. Zip Code
21875 | | 10g. Citizen of What Country?
USA | | | |
| 11. Marital Status
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: WHITE | | | |
| 15. Decedent's Education
(Specify only highest grade completed)
Elementary/Secondary (0-12) 3 Collage (1-4 or 5+) 3 | | | | 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)
HOMEMAKER | | 16b. Kind of Business/Industry
- | | | |
| 17. Father's Name (First, Middle, Last)
GEORGE BROCHU | | | | 18. Mother's Name (First, Middle, Maiden Surname)
MALLVINA LeMAY | | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
BEATRICE PROVOST/DAUGHTER | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
908 E. STATE STREET, DELMAR, MD 21875 | | | | | |
| 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
ST. STEPHEN'S CEMETERY | | Date
5/17 | | 20c. Location - City or Town, State
DELMAR, DELAWARE | | | |
| 21. Signature of Funeral Service Licensee
<i>Donald D. Zeller</i> | | | | 22. Name and Address of Facility
ZELLER FUNERAL HOME, 1212 OLD OCEAN CITY ROAD
P. O. BOX 3171, SALISBURY, MD 21802 | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

e. Hypoperfusion due to hypertension. hours
Due to (or as a consequence of):
b. Heart attack. 2-4 days
Due to (or as a consequence of):
c. Respiratory failure. hours
Due to (or as a consequence of):
d. Dehydration. several days | | | | | | | | Approximate Interval Between Onset and Death | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Failure to thrive
old age | | | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | |
| 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death?
N/A | | | | | | | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. Manner of Death
<input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation
<input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined
<input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how Injury occurred | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier
<i>Khalil Gorkui</i> MD | | 29c. License number
CI-0004569 | | 29d. Date signed (Month, Day, Year)
5/16/96 | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
KHALIL GORKUI 8 EGROVE ST DELMAR DE 19940 | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
MAY 16 1996 | | 32. Registrar's Signature
<i>John Davidson Randall</i> | | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

96 15797

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
EDWARD T. WHITE | | | | 2. DATE OF DEATH
MONTH May DAY 9 YEAR 1996 | | 3. TIME OF DEATH
12:00 Noon | |
| 4. SOCIAL SECURITY NUMBER
218-32-2759 | | 5. SEX
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
61 YRS. | | 7. DATE OF BIRTH (Month, Day, Year)
OCT. 14 1934 | |
| 8. FACILITY NAME (If not institution, give street and number)
GENESIS ELDER CARE SPA CREEK | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
ANNAPOLIS | | 9c. COUNTY OF DEATH
MARYLAND | |
| 10a. STATE
MARYLAND | | 10b. COUNTY
ANNE ARUNDEL | | 10c. CITY, TOWN OR LOCATION
ANNAPOLIS | | 10d. INSIDE CITY LIMITS?
<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER
701 GLENWOOD STREET APT. 412 | | | | 10f. ZIP CODE
21401 | | 10g. CITIZEN OF WHAT COUNTRY?
US | |
| 11. MARITAL STATUS
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify: BLACK | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12) 8th College (1-4 or 5+) 0 | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
TRUCK DRIVER | | 16b. KIND OF BUSINESS/INDUSTRY
KATCHEF BROS. CORP. | | | |
| 17. FATHER'S NAME (First, Middle, Last)
THEODORE WHITE | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
CORA SOMMERVILLE | | | |
| 19a. INFORMANT'S NAME (Type/Print)
SYLVIA W. NOLAN (SISTER) | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1353 SHIRLEYVILLE RD. ARNOLD, MD. 21012 | | | |
| 20a. METHOD OF DISPOSITION
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
ANNAPOLIS MEM. GARDENS | | DATE
5/15/96 | | 20c. LOCATION — City or Town, State
ANNAPOLIS, MD. | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
Harry D. Reese | | | | 22. NAME AND ADDRESS OF FACILITY
WM. REESE & SONS MORTUARY, P.A.
821 WEST ST. ANNAPOLIS, MD. 21401 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
IMMEDIATE CAUSE (Final disease or condition resulting in death) → widely metastatic Cancer
Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
a. Renal Cell carcinoma
b.
c.
d.
DUE TO (OR AS A CONSEQUENCE OF):
DUE TO (OR AS A CONSEQUENCE OF):
DUE TO (OR AS A CONSEQUENCE OF):
DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause, given in Part I.
Insulin dependent Diabetes mellitus
arterio-sclerosis 20 art. Hypertension | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
<input type="checkbox"/> YES <input type="checkbox"/> NO | | | | | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA
OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M | | 28c. INJURY AT WORK?
<input type="checkbox"/> YES <input type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | | | 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
Peter F. Verkouw | | | | 29c. LICENSE NUMBER
011653 | | 29d. DATE SIGNED (Month, Day, Year)
May 9, 1996 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
Peter F. Verkouw, MD 2003 MED PKWY Annapolis, MD, 21401 | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
MAY 13 1996 | | 32. REGISTRAR'S SIGNATURE
Jake Davidson-Randall | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

96 15798

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 15799

Certificate of Death

Reg. No.

Amended #26.P.G.C. 5-10-96 CR

| | | | | | | | | | |
|--|---|--|---|---|---|--|--|---|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Willie Clifford Williams | | | | 2. Date of Death
Month Day Year
May 4 1996 | | 3. Time of Death
2:30 PM | | |
| | 4a. Facility Name (If not institution, give street and number)
11805 Shadystone Terrace | | | | 4b. City, Town, or Location of Death
Mitchellville | | 4c. County of Death
Prince George's | | |
| Funeral
Director | 5. Social Security Number
254 50 8086 | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)
59 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth (Month, Day, Year)
June 14, 1936 | 9. Birthplace (State or Foreign Country)
Georgia | |
| | Usual Residence of Decedent | | | | | | | | |
| 10a. State
Maryland | | 10b. County
Prince George's | | 10c. City, Town or Location
Mitchellville | | | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | |
| 10e. Street and Number
11805 Shadystone Terrace | | | | 10f. Zip Code
20721 | | 10g. Citizen of What Country?
United States | | | |
| 11. Marital Status
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
If Yes, Give Year or Dates: 54-57 | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: Black | | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 5+ College (1-4 or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Lieutenant | | 16b. Kind of Business/Industry
US Supreme Court | | | |
| 17. Father's Name (First, Middle, Last)
Nathaniel Z. Williams | | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Willie Mae Harris | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
Betty J. Williams | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
11805 Shadystone Terrace Mitchellville Md. 20721 | | | | | |
| 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Hamblen Memorial Gardens | | Date
5/10/96 | | 20c. Location - City or Town, State
Morristown TN. | | |
| 21. Signature of Funeral Service Licensee
Robert E. Evans, Pres. | | | | 22. Name and Address of Facility
Robert E. Evans Funeral Home, P.A.
16000 Annapolis Rd. Bowie Md. 20715 | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

a. CARDIOPULMONARY ARREST
Due to (or as a consequence of):

b. METASTATIC GASTRIC CARCINOMA
Due to (or as a consequence of):

c. SEVERE ANEMIA
Due to (or as a consequence of):

d. GASTRIC INTESTINAL BLEEDING | | | | | | | | Approximate Interval Between Onset and Death
MINUTES
3 yrs
MONTHS
DAYS | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | |
| | | | | | | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation
<input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined
<input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input type="checkbox"/> No | | 28d. Describe how injury occurred | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| 29e. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | | |
| 29b. Signature and title of certifier
[Signature] | | | | 29c. License number
D31069 | | 29d. Date signed (Month, Day, Year)
7 MAY 96 | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
George Bone M.D. 9602 F. Martin Luther King Jr. Highway Lanham Md. | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
MAY 10 1996 | | | | 32. Registrar's Signature
[Signature] | | | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 15800

| | | | | | | | | |
|--|--|--|---|---|--|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
LEROY WHITLEY | | | | 2. Date of Death
Month Day Year
APRIL 30 1996 | | 3. Time of Death
1720 P | |
| | 4a. Facility Name (If not institution, give street and number)
PRINCE GEORGES HOSPITAL | | | | 4b. City, Town, or Location of Death
CHEVERLY | | 4c. County of Death
PRINCE GEORGES | |
| Funeral
Director | 5. Social Security Number
243-68-1898 | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)
52 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth (Month, Day, Year)
2/2/1944 | 9. Birthplace (State or Foreign Country)
North Carolina |
| | 10a. State
MD | | 10b. County
P.G. | | 10c. City, Town or Location
Temple Hills | | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | |
| To Be Completed by Funeral Director | 10a. Street and Number
3402 27th Ave. | | | | 10f. Zip Code
20748 | | 10g. Citizen of What Country?
U.S.A. | |
| | 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: Black | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (1-4 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Fork Lift Operator | | 16b. Kind of Business/Industry
Private | | | |
| | 17. Father's Name (First, Middle, Last)
unknown | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Cleo Whitley | | | |
| | 19a. Informant's Name/Relationship (Type, Print)
Sarah Whitley wife | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
3402 27th Ave. Temple Hills, Md. 20748 | | | |
| | 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Harmony Cemetery | | Date
5/8/96 | 20c. Location - City or Town, State
Landover, Md. | | |
| | 21. Signature of Funeral Service Licensee
<i>Prince Edwards</i> | | 22. Name and Address of Facility
Hodges and Edwards
3910 Silver Hill RD. Suitland Md. | | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
Immediate Cause (Final disease or condition resulting in death)
a. Multiple gunshot wounds to torso
Due to (or as a consequence of):
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of):
Sequitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | |
| | | | | | | | 24a. Was an autopsy performed?
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | |
| Medical Certification: To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner?
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input checked="" type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify) | | | | | |
| | 27. Manner of Death
1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation
2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined
3 <input type="checkbox"/> Suicide 4 <input checked="" type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day, Year)
KING 4-30-96 | | 28b. Time of Injury
0700 P M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | |
| | | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
SILVERDALE | | 28d. Describe how injury occurred
SHOTS TO TORSO SHOTS. | | | |
| | | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State)
2320 PASKUNY TEMPLEHILLS, PRINCE GEORGES, MD | | | |
| State
Registrar | 29a. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier
<i>Hayden Smith</i> | | 29c. License number
O.C.M.E | | 29d. Date signed (Month, Day, Year)
MAY 01, 1996 | |
| | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
MARION D. KOSKUN 111 Penn Street, Baltimore, Maryland 21201 | | | | | | | |
| | 31. Date filed (Month, Day, Year)
MAY 06 1996 | | 32. Registrar's Signature
<i>John D. ...</i> | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 96 15801

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

FANNIE LUERS WRIGHT

2. Date of Death

Month Day Year
May 3, 1996

3. Time of Death

11:10 am

Funeral
Director

4a. Facility Name (If not institution, give street and number)

Magnolia Gardens Nursing Home

4b. City, Town, or Location of Death

Lanham

4c. County of Death

Prince George's

5. Social Security Number

213-01-8929

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

99

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

6. Date of Birth

(Month, Day, Year)
Sept. 2, 1896

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

Prince George's

10c. City, Town or Location

Bowie

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

P.O. Box 173

10f. Zip Code

20719

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
8

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Proprietor - Owner

16b. Kind of Business/Industry

Dry Goods Store

17. Father's Name (First, Middle, Last)

Frank Bernard Luers

18. Mother's Name (First, Middle, Maiden Surname)

Maggie Ann Disney

19a. Informant's Name/Relationship (Type, Print)

Miss. Fannie L. Basim / niece

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

P.O. Box 173, Bowie, Maryland 20719

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Ft. Lincoln Cemetery

Date

5/06/1996

20c. Location - City or Town, State

Brentwood, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Francis Gasch's Sons Funeral Home, P.A.
4739 Baltimore Avenue, Hyattsville, MD 2078123a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)e. Uroperis
Due to (or as a consequence of):b. old age
Due to (or as a consequence of):c.
Due to (or as a consequence of):d.
Due to (or as a consequence of):Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) LastApproximate
Interval Between
Onset and Death

1-2

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?
1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
Investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide
4 ☐ Homicide28a. Date of Injury
(Month, Day, Year)28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

29c. License number

D3443

29d. Date signed (Month, Day, Year)

5/6/96

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Andrew Dobin, M.D. 3231 Superior Lane #A-6, Bowie, Maryland 20715-2206

31. Date filed (Month, Day, Year)

MAY 07 1996

32. Registrar's Signature

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Journal of Management Studies

Abstract

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 96 15802

Certificate of Death

Reg. No.

| | | | | | | | | | | | |
|--|---|--|---|--|--|--|--|--|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
LORETTA WALLBECK | | | | 2. Date of Death
Month Day Year
May 4, 1996 | | | | 3. Time of Death
12:30 pm | | |
| | 4a. Facility Name (If not institution, give street and number)
Sacred Heart Home | | | | 4b. City, Town, or Location of Death
Hyattsville | | | | 4c. County of Death
Prince George's | | |
| Funeral
Director | 5. Social Security Number
331-18-6643 | | 6. Sex
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday)
86 Yrs. | | 8. Date of Birth (Month, Day, Year)
Dec. 19, 1909 | | 9. Birthplace (State or Foreign Country)
Illinois | | |
| | Usual Residence of Decedent | | | | | | | | | | |
| To Be Completed by Funeral Director | 10a. State
MD | | 10b. County
Prince George's | | 10c. City, Town or Location
Hyattsville | | | | 10d. Inside City Limits
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | |
| | 10e. Street and Number
5805 42nd Avenue #602 | | | | 10f. Zip Code
20781 | | 10g. Citizen of What Country?
U.S.A. | | | | |
| | 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc.
Specify: White | | | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 Collegia (1-4or 5+) | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Office Worker | | | 16b. Kind of Business/Industry
Private | | | | |
| | 17. Father's Name (First, Middle, Last)
William D. Keeley | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Margaret Ann Kelley | | | | | | |
| | 19a. Informant's Name/Relationship (Type, Print)
Diane Martinez (Daughter) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
4402 Underwood Street, Hyattsville, Maryland 20782 | | | | | | |
| | 20a. Method of Disposition
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Fort Lincoln Cemetery | | 20c. Date
05/08/96 | | 20d. Location - City or Town, State
Brentwood, Maryland | | | | |
| | 21. Signature of Funeral Service Licensee
 | | | | 22. Name and Address of Facility
Francis Gasch's Sons Funeral Home, P.A.
4739 Baltimore Avenue, Hyattsville, MD 20781 | | | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. <u>Bilateral Lower Lobe Pneumonia</u>
Due to (or as a consequence of):

b. <u>Hypertensive Cardiovascular Disease & Heart Failure</u>
Due to (or as a consequence of):

c. _____
Due to (or as a consequence of):

d. _____

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

Approximate Interval Between Onset and Death
2 Days
Years | | | | | | | | | | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown

24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No

24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | | | | | | |
| Medical Certification: To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify) | | | | | | | | |
| | 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation
2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined
3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | | |
| | | | 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | |
| | 29a. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | |
| 2 | 29b. Signature and title of certifier
 | | | | 29c. License number
D26331 | | 29d. Date signed (Month, Day, Year)
5/4/96 | | | | |
| | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Marta Anne Schneider, M.D. 5401 MacArthur Boulevard, N.W., Washington, DC 20016 | | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
MAY 08 1996 | | | | | | | | | | 32. Registrar's Signature
 | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 15803

Certificate of Death

Reg. No.

| | | | | | | | | | |
|--|--|---|--|---|--|--|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Jenise McNair Washington | | | | 2. Date of Death
Month 05 Day 05 Year 96 | | 3. Time of Death
9:15a.m. | | |
| | 4a. Facility Name (If not institution, give street and number)
1428 Potomac Heights Dr. | | | | 4b. City, Town, or Location of Death
Ft. Washington | | 4c. County of Death
P.G. | | |
| Funeral
Director | 5. Social Security Number
578-96-1367 | | 6. Sex
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)
33 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth
(Month, Day, Year)
3/2/63 | 9. Birthplace (State or Foreign Country)
Wash. D.C. | |
| | Usual Residence of Decedent | | | | | | | | |
| 10a. State
MD | | 10b. County
P.G. | | 10c. City, Town or Location
Ft. Washington | | | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | |
| 10e. Street and Number
1428 Potomac Heights Dr. | | | | 10f. Zip Code
20744 | | 10g. Citizen of What Country?
U.S.A. | | | |
| 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc.
Specify: Black | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) College (1-4 or 5+)
2 | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Economist Assistant | | | 16b. Kind of Business/Industry
Labor Dept. | | |
| 17. Father's Name (First, Middle, Last)
William Stanfield | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Ruby McNair (Jennings) | | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
Alan Washington | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1428 Potomac Heights Dr. Ft. Wash. MD. 20744 | | | | | |
| 20a. Method of Disposition
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Washington National Cem. 5/9/96 Suitland, Md. | | 20c. Location - City or Town, State
Hodges and Edwards | | | |
| 21. Signature of Funeral Service Licensee
<i>Jenise Edwards</i> | | | | 22. Name and Address of Facility
3910 Silver Hill Rd. Suitland, Md. 20746 | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

a. <i>Cytomegalovirus infection</i>
Due to (or as a consequence of):
b. <i>Acquired Immunodeficiency Syndrome</i>
Due to (or as a consequence of):
c. <i>Human Immunodeficiency Virus Infection</i>
Due to (or as a consequence of):
d.

Approximate interval Between Onset and Death
<i>6 months</i>
<i>3 years</i>
<i>14 years</i> | | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
<i>Mycobacterium avium-intracellulare - bacteria</i> | | | | | | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | |
| 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | |
| 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one)
Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. Manner of Death
1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide
5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| 29a. Certifier (Check only one)
1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | 29c. License number
027890 | | 29d. Date signed (Month, Day, Year)
May 8, 1996 | | | |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)
Mark Synder MD. 1011 North Capital St. N.E. 20002 | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
MAY 08 1996 | | | | 32. Registrar's Signature
<i>Jenise Edwards</i> | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State Registrar

Journal of Management Education 30(6)

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State of Maryland / Department of Health and Mental Hygiene 96 15804

Certificate of Death

Reg. No.

| | | | | | | | | |
|---|---|--|---|--------------------------------|--|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Helen Pratt Wheeler | | | | 2. Date of Death
Month Day Year
May 5 1996 | | 3. Time of Death
2:05 P.M. | |
| | 4a. Facility Name (If not institution, give street and number)
Doctors' Community Hospital | | | | 4b. City, Town, or Location of Death
Lanham | | 4c. County of Death
Prince George's | |
| Funeral
Director | 5. Social Security Number
579 10 1555 | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)
81 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth (Month, Day, Year)
8/3/14 | 9. Birthplace (State or Foreign Country)
Massachusetts | |
| | Usual Residence of Decedent | | | | | | | |
| To Be Completed by Funeral Director | 10a. State
Maryland | 10b. County
Prince George's | 10c. City, Town or Location
New Carrollton | | | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | |
| | 10e. Street and Number
6102 86th Ave. | | | 10f. Zip Code
20784 | | 10g. Citizen of What Country?
United States | | |
| | 11. Marital Status
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: White | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 4 College (1-4 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Homemaker | | | 16b. Kind of Business/Industry
Own Home | | |
| | 17. Father's Name (First, Middle, Last)
Harrison Pratt | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Ada Hall | | | |
| | 19a. Informant's Name/Relationship (Type, Print)
Nancy Staples | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
5841 Contee Drive Lothian Md. 20711 | | | |
| | 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Fort Lincoln Cemetery 5/9/96 | | Data | | 20c. Location - City or Town, State
Brentwood Maryland | |
| | 21. Signature of Funeral Service Licensee
Robert E. Evans | | | | 22. Name and Address of Facility
Robert E. Evans Funeral Home, P.A.
16000 Annapolis Road Bowie Maryland 20715 | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
Immediate Cause (Final disease or condition resulting in death)
a. Pneumonia
Due to (or as a consequence of):
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | |
| | Approximate Interval Between Onset and Death
4 weeks | | | | | | | |
| To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate. | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
- Breast Cancer
- Respiratory Failure | | | | | | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | |
| | | | | | | | 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | |
| | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| | 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 28. Place of Death (Check only one)
Hospital: <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify) | | | | | |
| | 27. Manner of Death
<input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation
2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined
3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| | | | 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28d. Describe how injury occurred | |
| | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| | 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| | 29b. Signature and title of certifier
Riad Dakhel M.D. | | | | 29c. License number
D 26492 | | 29d. Date signed (Month, Day, Year)
5.6.96 | |
| | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Riad Dakhel M.D. 4000 Mitchellville Rd, Bowie, MD 20716 | | | | | | | |
| State
Registrar | 31. Date filed (Month, Day, Year)
MAY 08 1996 | | | | 32. Registrar's Signature
Julia Anderson | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

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State of Maryland / Department of Health and Mental Hygiene

96 15805

Certificate of Death

Reg. No.

| | | | | | | | | |
|--|--|---------------------------------------|---|--|--|--|---|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
VIVERT A. Willis | | | | 2. Date of Death
Month Day Year
May 2 1996 | | 3. Time of Death
5:55AM | |
| | 4a. Facility Name (If not institution, give street and number)
Prince George's Hospital | | | | 4b. City, Town, or Location of Death
Cheverly | | 4c. County of Death
Prince George's | |
| Funeral
Director | 5. Social Security Number
206-07-8355 | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)
94 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth (Month, Day, Year)
01-07-02 | 9. Birthplace (State or Foreign Country)
Pittsburgh PA |
| | Usual Residence of Decedent | | | | | | | |
| To Be Completed by Funeral Director | 10a. State
MD | 10b. County
Prince George's | 10c. City, Town or Location
Capital Heights | | | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | |
| | 10e. Street and Number
5001 N. Englewood Drive | | | 10f. Zip Code
20743 | | 10g. Citizen of What Country?
USA | | |
| | 11. Marital Status
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: Black | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 11th College (1-4or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Electrician | | 16b. Kind of Business/Industry
Private | | | |
| Physician
/Medical
Examiner | 17. Father's Name (First, Middle, Last)
Frank Willis | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Sarah Jones | | | |
| | 19a. Informant's Name/Relationship (Type, Print)
Mary Willis/Wife | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
5001 N. Englewood Dr. Capital Hgt, MD 20743 | | | |
| | 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Harmony Memorial Pk | | Date
5/8/96 | 20c. Location - City or Town, State
Landover, MD | | |
| | 21. Signature of Funeral Service Licensee
Kimberly C. Buscetta | | 22. Name and Address of Facility
J. B. Jenkins Funeral Home
7474 Landover Rd, Landover, MD 20785 | | | | | |
| Medical Certification: To Be Completed by Physician/Medical Examiner | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

a. Cardio-Respiratory arrest
Due to (or as a consequence of):
b. Cerebral Vascular accident
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.
Sequitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | |
| | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | | | |
| | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No | | | |
| To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. | 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28. Place of Death (Check only one)
Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| | 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation
<input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined
<input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | 28e. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| | 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | |
| 4 | 29b. Signature and title of certifier
Joseph Vaughn | | | | 29c. License number
D-20643 | | 29d. Date signed (Month, Day, Year)
5/2/96 | |
| | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Joseph Vaughn, M.D., 6492 Landover Rd, Suite B, Landover, MD 20785 | | | | | | | |
| State
Registrar | 31. Date filed (Month, Day, Year)
MAY 08 1996 | | | | 32. Registrar's Signature
John Davidson | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

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State of Maryland / Department of Health and Mental Hygiene

96 15806

Certificate of Death

Reg. No.

| | | | | | | | | | | | |
|---|---|---|--|--|--|--|--|--|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
NOVILLA MARGARET | | | | 2. Date of Death
Month: MAY 5, Day: 1996 Year: 2145 | | | | 3. Time of Death
2145 | | |
| | 4a. Facility Name (If not institution, give street and number)
PENINSULA REGIONAL MEDICAL CENTER | | | | 4b. City, Town, or Location of Death
SALISBURY | | | | 4c. County of Death
WICOMICO | | |
| Funeral
Director | 5. Social Security Number
222-26-1317 | | 6. Sex
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday)
90 Yrs. | | 8. Date of Birth (Month, Day, Year)
8/11/1905 | | 9. Birthplace (State or Foreign Country)
Virginia | | |
| | Usual Residence of Decedent | | | | | | | | | | |
| 10a. State
Delaware | | 10b. County
Sussex | | 10c. City, Town or Location
Delmar | | | | 10d. Inside City Limits
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | |
| 10e. Street and Number
R.D. 1 Box 278 | | | | 10f. Zip Code
19940 | | 10g. Citizen of What Country?
USA | | | | | |
| 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: Black | | | | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 7 College (1-4or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
homemaker | | 16b. Kind of Business/Industry
homemaking | | | | | |
| 17. Father's Name (First, Middle, Last)
Benjamin Smith | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Kathryn Gunter | | | | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
John F. Wescott | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
R.D. 1 Box 279, Delmar, Delaware 19940 | | | | | | | |
| 20a. Method of Disposition
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Curtis Cemetery | | Date
5/10/96 | | 20c. Location - City or Town, State
Bishopville, Md. | | | | | |
| 21. Signature of Funeral Service Licensee
<i>Richard J. Watson</i> | | | | 22. Name and Address of Facility
Watson Funeral Home, Millsboro, Del. 19966 | | | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | | | | Approximate Interval Between Onset and Death | |
| Immediate Cause (Final disease or condition resulting in death)
e. <u>UROSEPSIS</u>
Due to (or as a consequence of): | | | | | | | | | | 7 DAYS | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. | | | | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I.
<u>GASTROINTESTINAL BLEEDING</u> | | | | | | | | | | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown | |
| | | | | | | | | | | 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | |
| | | | | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | |
| 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify) | | | | | | | | | |
| 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation
2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined
3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | | | |
| | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| 29a. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the causa(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the causa(s) and manner stated. | | | | | | | | | | | |
| 29b. Signature and title of certifier
<i>Alwan Appan MD</i> | | | | 29c. License number
D44061 | | 29d. Date signed (Month, Day, Year)
MAY 6 1996 | | | | | |
| 30. Name and address of person who completed causa of death (Item 23e) (Type, Print)
AKWASI APPAN 540 RIVERSIDE DRIVE SUITE 4 SALISBURY MD 21801 | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
MAY 08 1996 | | | | 32. Registrar's Signature
<i>John Andrew Randall</i> | | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

2008-2009

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State of Maryland / Department of Health and Mental Hygiene

96 15807

Certificate of Death

Reg. No.

| | | | | | | | | | |
|--|--|---------------------------------------|---|---|--|--|--|---|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Gregory P. White | | | | 2. Date of Death
Month Day Year
MAY 10 1996 | | 3. Time of Death
7:29 PM | | |
| | 4a. Facility Name (If not institution, give street and number)
Physicians Memorial Hospital | | | | 4b. City, Town, or Location of Death
La Plata | | 4c. County of Death
Charles | | |
| Funeral
Director | 5. Social Security Number
560-48-1561 | | 6. Sex
1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | 7. Age (In yrs. last birthday)
59 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth
Month Day Year
April 2, 1937 | 9. Birthplace (State or Foreign Country)
New Jersey | |
| | Usual Residence of Decedent | | | | | | | | |
| To Be Completed by Funeral Director | 10a. State
Maryland | | 10b. County
Charles | | 10c. City, Town or Location
Waldorf | | 10d. Inside City Limits
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | |
| | 10e. Street and Number
3609 Osborne Court | | | | 10f. Zip Code
20602 | | 10g. Citizen of What Country?
U. S. A. | | |
| | 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No
If Yes, Give Year or Dates: 1956-1959 | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: White | | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) College (1-4 or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Engineering Manager | | 16b. Kind of Business/Industry
N.O.A.H. | | |
| | 17. Father's Name (First, Middle, Last)
Edmond E. White | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Beatrice Rahn | | | | |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print)
Jeanne C. White | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
3609 Osborne Court, Waldorf, Maryland 20602 | | | | |
| | 20a. Method of Disposition
1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Salisbury Crematory | | Date
5/16/96 | | 20c. Location - City or Town, State
Salisbury, Maryland | | |
| | 21. Signature of Funeral Service Licensee
Constance Helen Baker | | | | 22. Name and Address of Facility
Sage Funeral Home
Chincoteague, Virginia 23336 | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
Immediate Cause (Final disease or condition resulting in death)
e. MULTI-ORGAN FAILURE
Due to (or as a consequence of):
b. ACUTE MYOCARDIAL INFARCTION
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.
Approximate Interval Between Onset and Death
48 HRS
48 HRS | | | | | | | | |
| | 23b. Did tobacco use contribute to the cause of death?
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
SEPSIS
RESPIRATORY FAILURE | | | | | | 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one)
Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide
5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how Injury occurred | |
| 29a. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | 29b. Signature and title of certifier
Ashvinkumar J Patel MD | | | | 29c. License number
D-44436 | |
| 29d. Date signed (Month, Day, Year)
5/10/96 | | | | 29e. Name and address of person who completed cause of death (Item 23a) (Type, Print)
ASHVINKUMAR J PATEL MD 603 POST OFFICE RD #207 WALDORF MD 20602 | | | | | |
| 31. Date filed (Month, Day, Year)
MAY 13 1996 | | | | 32. Registrar's Signature
John A. Russell | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

11-1-1971
11-1-1971

11-1-1971

11-1-1971

11-1-1971

11-1-1971

11-1-1971

11-1-1971

11-1-1971

11-1-1971

11-1-1971

11-1-1971

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 15808

| | | | | | | | | |
|--|---|--|---|--|--|---|---|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
MALCOLM T. Winfree | | | | 2. Date of Death
Month May Day 5 Year 1996 | | 3. Time of Death
11:57 AM | |
| | 4a. Facility Name (If not Institution, give street and number)
PENINSULA REGIONAL MEDICAL CENTER | | | | 4b. City, Town, or Location of Death
SALISBURY | | 4c. County of Death
WICOMICO | |
| Funeral
Director | 5. Social Security Number
214-10-9026 | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday)
83 Yrs. | | 8. Date of Birth (Month, Day, Year)
JUNE 11, 1912 | |
| | 9. Birthplace (State or Foreign Country)
W/VA. | | 10a. State
MD. | | 10b. County
WICOMICO | | 10c. City, Town or Location
SALISBURY | |
| To Be Completed by Funeral Director | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 10e. Street and Number
614 DOVER STREET | | 10f. Zip Code
21804 | | 10g. Citizen of What Country?
U.S.A. | |
| | 11. Marital Status
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
If Yes, Give Year or Dates: WWII | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: WHITE | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 Collage (1-4 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
GENERAL MANAGER | | 16b. Kind of Business/Industry
DRY CLEANING CO. | | | |
| | 17. Father's Name (First, Middle, Last)
EDGAR WINFREE | | | | 18. Mother's Name (First, Middle, Maiden Surname)
ETHEL HUFFMAN | | | |
| | 19a. Informant's Name/Relationship (Type, Print)
SARAH WINFREE | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
614 DOVER STREET, SALISBURY, MD. 21804 | | | |
| | 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
OLD SPRING HILL CEMETERY | | 20c. Location - City or Town, State
5/8 HEBRON, MARYLAND | | | |
| | 21. Signature of Funeral Service Licensee
<i>Guadalupe</i> | | 22. Name and Address of Facility
BOUNDS FUNERAL HOME, 705 E. MAIN ST., SALISBURY, MD. | | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
e. Myocardial Infarction
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of): | | | | | | | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | |
| | | | | | | | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| Medical Certification: To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| | 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input type="checkbox"/> No | |
| | | | 28a. Place of injury - At home, farm, street, factory, office building, etc. (Specify) | | 28d. Describe how injury occurred | | | |
| | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| | 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | |
| State Registrar | 29b. Signature and title of certifier
<i>Benjamin H. Meyer</i> | | | | 29c. License number
D 30743 | | 29d. Date signed (Month, Day, Year)
5/5/96 | |
| | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Benjamin H. Meyer M.D. 403 Quincy St. Salisbury, Md. | | | | | | | |
| | 31. Date filed (Month, Day, Year)
MAY 07 1996 | | 32. Registrar's Signature
<i>John A. Russell</i> | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

Funeral
Director

1. Decedent's Name (First, Middle, Last)

ROBERT G. ANDERSON

2. Date of Death

4/17/96

3. Time of Death

1410

4a. Facility Name (If not institution, give street and number)

PENINSULA REGIONAL MEDICAL CENTER

4b. City, Town, or Location of Death

SALISBURY

4c. County of Death

WICOMICO

5. Social Security Number

177-14-7748

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

76 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

Oct. 22, 1919 Pennsylvania

9. Birthplace (State or Foreign Country)

Usual Residence of Decedent

10a. State

Maryland

10b. County

Wicomico

10c. City, Town or Location

Hebron

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10a. Street and Number

101 CULVER

101 Culver Street - P.O. Box 117

10f. Zip Code

21830

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No
If Yes, Give Year or Dates: WWII

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4or 5+)

1

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Mechanic

16b. Kind of Business/Industry

County Road Department

17. Father's Name (First, Middle, Last)

Alexander Anderson

18. Mother's Name (First, Middle, Maiden Surname)

Beatrice Mae Jermyn

19a. Informant's Name/Relationship (Type, Print)

Emily T. Anderson/Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

101 Culver Street - P.O. Box 11 - Hebron, MD. 21830

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☒ Other (Specify) State rem.

20b. Place of Disposition (Name of cemetery, crematory or other place)

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Ronald S. Wade, Dir.

22. Name and Address of Facility

State Anatomy Board - 655 W. Baltimore Street
Baltimore, Maryland 21201-1559

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

e. Respiratory Failure

Due to (or as a consequence of):

b. End Stage Pulmonary Fibrosis + Pulmonary

Due to (or as a consequence of):

c. Hypertension; possibly Asbestos related.

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Coronary Artery Disease

Heart Failure

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient

2 ☐ ER/Outpatient

3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Joseph C. Anderson MD

29c. License number

044069

29d. Date signed (Month, Day, Year)

4-17-96

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

J. Cinderella, MD 106 Midland St # 104 Salisbury MD 21801

31. Date filed (Month, Day, Year)

MAY 29 1996

32. Registrar's Signature

John Davidson-Randall

State Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 15810

Certificate of Death

Reg. No.

| | | | | | | | | |
|---|---|--|---|---|--|--------------------------------|---|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
George, Austin JR. | | | | 2. Date of Death
Month May Day 24 Year 96 | | 3. Time of Death
0:83/AM | |
| | 4a. Facility Name (If not institution, give street and number)
ST. AGNES HOSPITAL | | | | 4b. City, Town, or Location of Death
BALTIMORE | | 4c. County of Death
N/A | |
| Funeral
Director | 5. Social Security Number
219-05-9984 | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)
73 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth (Month, Day, Year)
08/19/22 | 9. Birthplace (State or Foreign Country)
MARYLAND |
| | Usual Residence of Decedent | | | | | | | |
| To Be Completed by Funeral Director | 10a. State
MD | | 10b. County
N/A | | 10c. City, Town or Location
BALTIMORE | | | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |
| | 10e. Street and Number
1100 WILDWOOD PARKWAY | | | | 10f. Zip Code
21229 | | 10g. Citizen of What Country?
US | |
| | 11. Marital Status
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: BLACK | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 9 College (1-4or 5+) -0- | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
CLERK | | | 16b. Kind of Business/Industry
CLOTHING | |
| | 17. Father's Name (First, Middle, Last)
GEORGE AUSTIN SR. | | | | 18. Mother's Name (First, Middle, Maiden Surname)
BESSIE PRINCE | | | |
| | 19a. Informant's Name/Relationship (Type, Print)
MARGARET DURHAM (SISTER) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
740 POPLAR GROVE ST. BALTIMORE, MD. 21216 | | | |
| | 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
BALTIMORE CEMETERY | | Date
5/30/96 | | 20c. Location - City or Town, State
BALTIMORE, MD. | |
| | 21. Signature of Funeral Service Licensee
<i>[Signature]</i> CFSP #281 | | | | 22. Name and Address of Facility
PHILLIPS FUNERAL HOME
1721-27 N. MONROE ST. BALTIMORE, MD. 21217 | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | |
| | Immediate Cause (Final disease or condition resulting in death)
e. CARDIAL ARRHYTHMIA
Due to (or as a consequence of):
b. ACUTE MYOCARDIAL INFARCTION
Due to (or as a consequence of):
c. ATHEROSCLEROTIC HEART DISEASE
Due to (or as a consequence of):
d. | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
CONGESTIVE HEART FAILURE
RENAL FAILURE
STATUS POST BREAST CARCINOMA. | | | | | | | | |
| 23b. Did tobacco use contribute to the cause of death?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | | | | |
| 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | |
| 26. Place of Death (Check only one)
Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | | | | | | | |
| 28a. Date of Injury (Month, Day, Year) | | | | | | | | |
| 28b. Time of Injury
M | | | | | | | | |
| 28c. Injury at Work?
<input type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | | |
| 28d. Describe how Injury occurred | | | | | | | | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | | | | | |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | |
| 29b. Signature and title of certifier
Viput Mantadik | | | | | | | | |
| 29c. License number
P 08217 | | | | | | | | |
| 29d. Date signed (Month, Day, Year)
MAY 24, 1996 | | | | | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
VIPUT MANTADIK ST. AGNES HOSPITAL BALTIMORE, MARYLAND | | | | | | | | |
| 31. Date filed (Month, Day, Year)
MAY 29 1996
<i>[Signature]</i> | | | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

10 + 1

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 15811

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Miriam P. Anservitz

2. Date of Death

May 25 1996 Year

3. Time of Death

2:55 P

4a. Facility Name (If not institution, give street and number)

Chesapeake Health Care Center

4b. City, Town, or Location of Death

Arnold

4c. County of Death

Anne Arundel

Funeral
Director

5. Social Security Number

263 41 6730

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

95 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Nov 10 1900

9. Birthplace (State or Foreign Country)

USA N.Y.

Usual Residence of Decedent

10a. State

Md

10b. County

Anne Arundel

10c. City, Town or Location

Millersville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

319 Chalet Drive

10f. Zip Code

21108

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify:
White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

Secretary

16b. Kind of Business/Industry

Law

17. Father's Name (First, Middle, Last)

Abraham Penziver

18. Mother's Name (First, Middle, Maiden Surname)

Bella Yakamufski

19a. Informant's Name/Relationship (Type, Print)

Marshall G. Anservitz

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

319 Chalet Drive, Arnold, Md 21108

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Metro

Data

5/27/96

20c. Location - City or Town, State

Baltimore

21. Signature of Funeral Service Licensee

Kendall S. Rome

22. Name and Address of Facility

Hardesty Funeral Home, P.A., 12 Ridgely Ave., Annapolis, Md 21401

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Acute Cerebrovascular Accident

Approximate Interval Between Onset and Death

1 Day

Due to (or as a consequence of):

Multiple Infarct Dementia

5 Years

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 5 ☐ Pending investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how Injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Whymach Attending Doctor

29c. License number

D 21684

29d. Date signed (Month, Day, Year)

5-28-96

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CIV. CYRIAC. N-D 1600 CRAIN WAY #106, GLENBURNIE, MD 21061

State Registrar

31. Date filed (Month, Day, Year)

MAY 29 1996

32. Registrar's Signature

W. J. Anderson

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital of Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

3

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 15812

Certificate of Death

Reg. No.

| | | | | | | | | |
|--|---|--|--|--|---|--|---|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
WALLACE DUANE BORTH | | | | 2. Date of Death
Month May Day 19 Year 1996 | | 3. Time of Death
1:30 p.m. | |
| | 4a. Facility Name (If not institution, give street and number)
1322 Turret Road | | | | 4b. City, Town, or Location of Death
Bel Air | | 4c. County of Death
Harford | |
| Funeral
Director | 5. Social Security Number
255-68-2581 | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday)
52 Yrs. | | 8. Date of Birth
Month Oct. Day 26 Year 1943 | |
| | 9. Birthplace (State or Foreign Country)
North Dakota | | 10a. State
Maryland | | 10b. County
Harford | | 10c. City, Town or Location
Bel Air | |
| To Be Completed by Funeral Director | 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 10e. Street and Number
1322 Turret Road | | 10f. Zip Code
21015 | | 10g. Citizen of What Country?
U.S.A. | |
| | 11. Marital Status
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
If Yes, Give Year or Dates: Vietnam | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: White | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 3 years College (1-4 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Insurance Agent | | 16b. Kind of Business/Industry
Insurance Company | | | |
| | 17. Father's Name (First, Middle, Last)
George Borth | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Lydia Martin | | | |
| | 19a. Informant's Name/Relationship (Type, Print)
Donna E. Borth (Wife) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1322 Turret Road, Bel Air, Md. 21015 | | | |
| | 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Highview Memorial Gardens | | Date
5/23/96 | | 20c. Location - City or Town, State
Fallston, Maryland | |
| | 21. Signature of Funeral Service Licensee
 | | 22. Name and Address of Facility
Schimunek Funeral Home of Bel Air, Inc.
610 W. MacPhail Road, Bel Air, Md. 21014 | | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

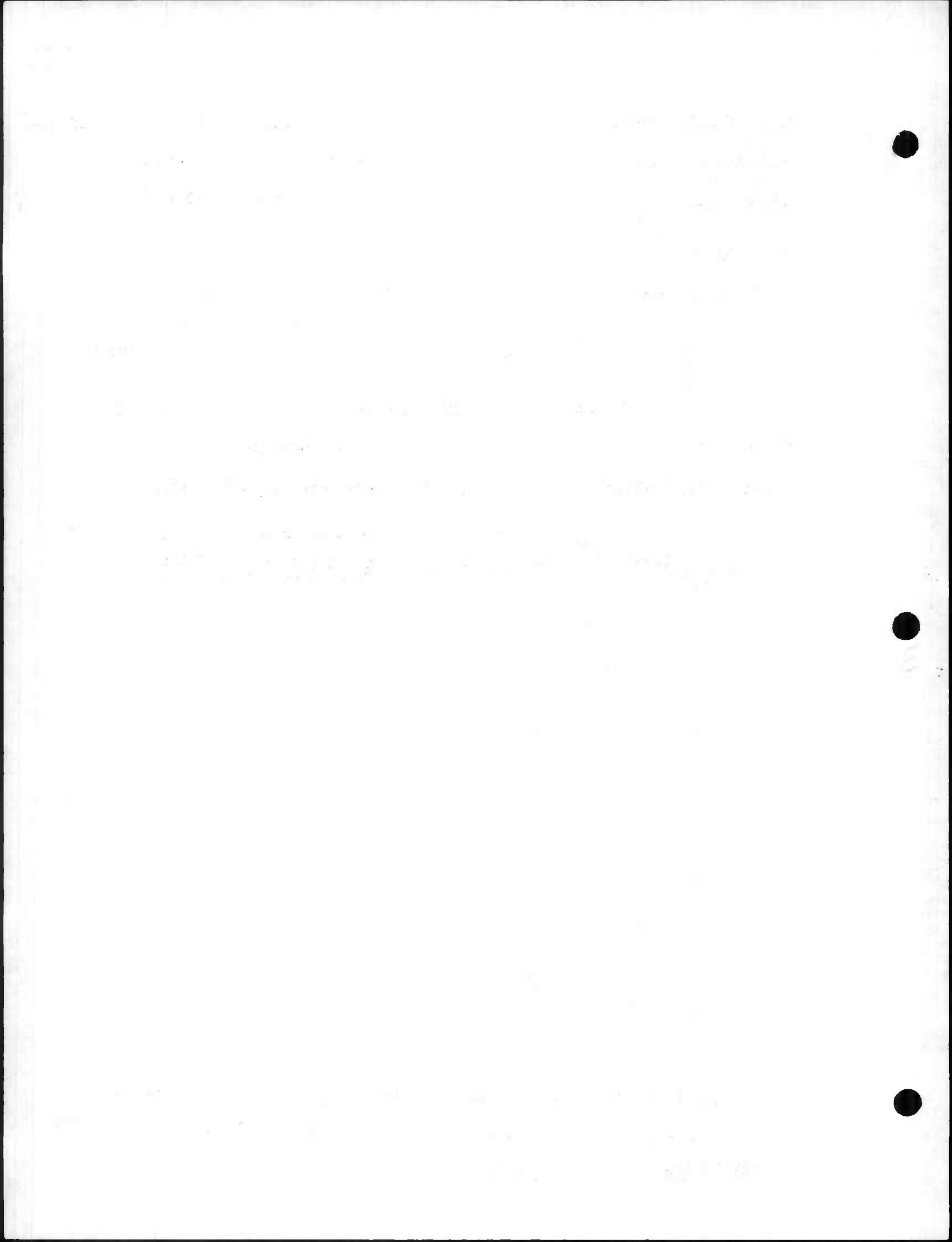
Immediate Cause (Final disease or condition resulting in death)

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

e. Dehydration
Due to (or as a consequence of):
b. metastatic cancer
Due to (or as a consequence of):
c. Renal cell cancer
Due to (or as a consequence of):
d. _____ | | | | | | | |
| | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | | | |
| | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | |
| Medical Certification: To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 28. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | |
| | 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| | 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| | 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | |
| | 29b. Signature and title of certifier
Kenneth S Kochmann MD | | | | 29c. License number
DY5421 | | 29d. Date signed (Month, Day, Year)
5/22/96 | |
| State Registrar | 30. Name and address of person who completed causa of death (Item 23a) (Type, Print)
Kenneth S Kochmann MD 1916 Bel Air Rd Fallston MD 21077 | | | | | | | |
| | 31. Date filed (Month, Day, Year)
MAY 29 1996 | | | | 32. Registrar's Signature
 | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



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State of Maryland / Department of Health and Mental Hygiene

96 15813

Certificate of Death

Reg. No.

| | | | | | | | | |
|--|--|---|---|--|--|--|---|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Charles J. BARRETT | | | | 2. Date of Death
Month Day Year
May 24, 1996 | | 3. Time of Death
12:47pm | |
| | 4a. Facility Name (If not institution, give street and number)
Franklin Square Hospital | | | | 4b. City, Town, or Location of Death
N/A | | 4c. County of Death
Baltimore County | |
| Funeral
Director | 5. Social Security Number
218-32-6080 | | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday)
59 Yrs. | | 8. Date of Birth (Month, Day, Year)
March 14, 1937 | |
| | 9. Birthplace (State or Foreign Country)
Maryland | | 10a. State
Maryland | | 10b. County
N/A | | 10c. City, Town or Location
Baltimore | |
| To Be Completed by Funeral Director | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 10e. Street and Number
4415 Kenwood Avenue | | 10f. Zip Code
21206 | | 10g. Citizen of What Country?
U.S.A. | |
| | 11. Marital Status
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: White | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12)
6th grade | | 16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Plumber | | 17. Kind of Business/Industry
Mitchell's Plumbing | | | |
| | 17. Father's Name (First, Middle, Last)
Richard Marion Barrett | | 18. Mother's Name (First, Middle, Maiden Surname)
Sophia Lee Steigerwald | | 19a. Informant's Name/Relationship (Type, Print) (Brother - Raymond L. Branham Jr. In-Law) | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
4512 Arizona Avenue, Baltimore, Maryland 21206 | |
| | 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Oak Lawn Cemetery | | 20c. Location - City or Town, State
5-28-96 Baltimore, Maryland | | | |
| | 21. Signature of Funeral Service Licensee
 | | 22. Name and Address of Facility
Schimunek Funeral Home
3331 Brehms Lane, Baltimore, Maryland 21213 | | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. Lung Cancer
Dua to (or as a consequence of):

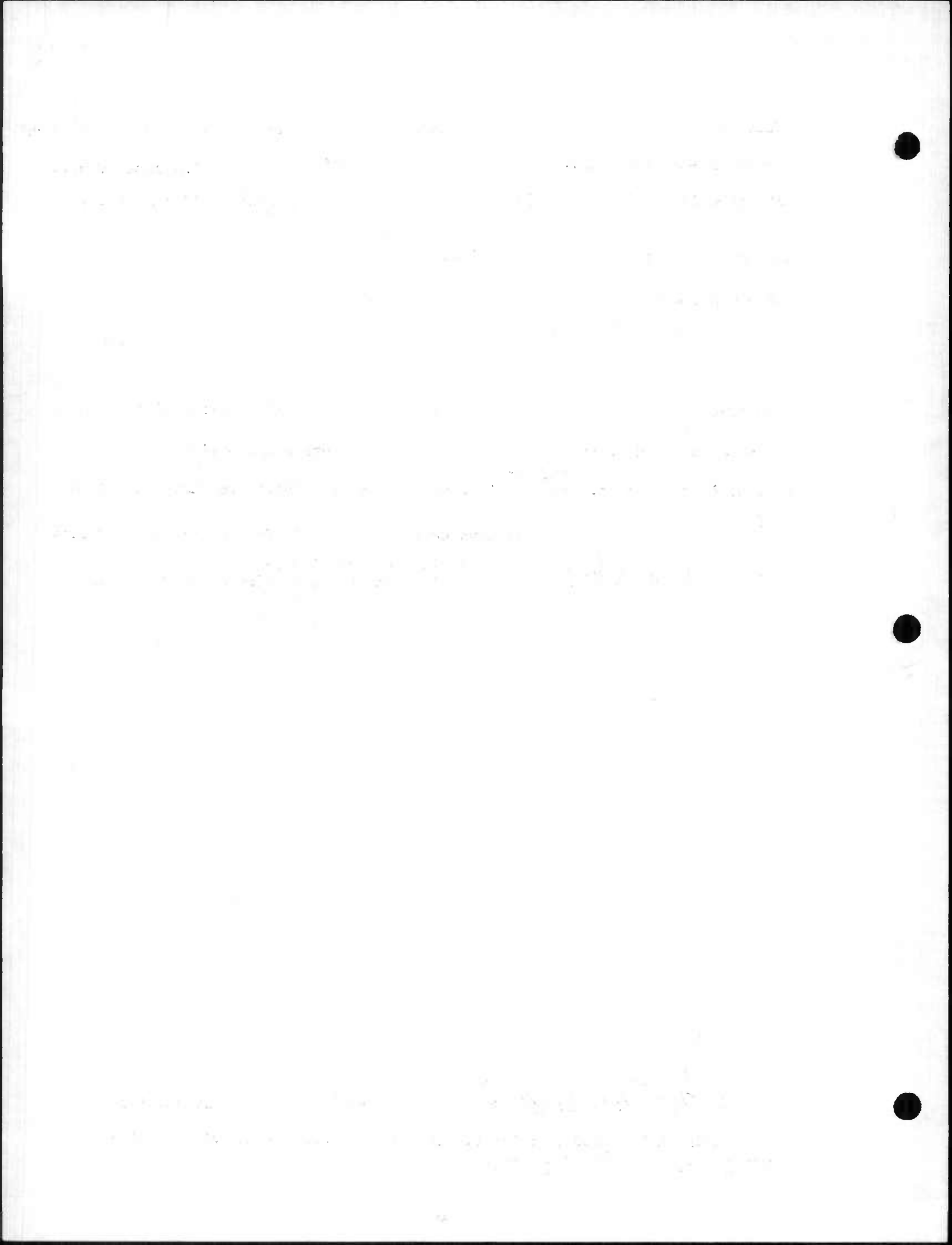
b.
Dua to (or as a consequence of):

c.
Dua to (or as a consequence of):

d.
Dua to (or as a consequence of): | | | | | | Approximate Interval Between Onset and Death
years | |
| | 23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | |
| | 23c. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown | | | | | | | |
| | 23d. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | 23e. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| 25. Was case referred to medical examiner?
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide
5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | |
| 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | |
| 29a. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier
 | | 29c. License number
D24875 | | 29d. Date signed (Month, Day, Year)
May 24, 1996 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Dan Morhaim, M.D. 9000 Franklin Square Drive, Baltimore, Maryland 21237 | | 31. Date filed (Month, Day, Year)
MAY 29 1996 | | 32. Registrar's Signature
 | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,




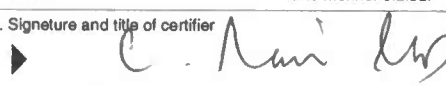

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State of Maryland / Department of Health and Mental Hygiene

96 15814

Certificate of Death

Reg. No.

| | | | | | | | | |
|--|--|--|--|--|---|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
FRANK BARNES | | | | 2. Date of Death
Month MAY Day 23 Year 1996 | | 3. Time of Death 09:30 AM | |
| | 4a. Facility Name (If not institution, give street and number)
Northwest Hospital Center | | | | 4b. City, Town, or Location of Death
Randallstown | | 4c. County of Death
Baltimore | |
| Funeral
Director | 5. Social Security Number
215-03-0355 | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday)
88 Yrs. | | 8. Date of Birth (Month, Day, Year)
Oct 24, 1907 | |
| | 9. Birthplace (State or Foreign Country)
Maryland | | 10a. State
Maryland | | 10b. County
Baltimore | | 10c. City, Town or Location
Randallstown | |
| 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 10e. Street and Number
9109 Liberty Rd. | | 10f. Zip Code
21133 | | 10g. Citizen of What Country?
USA | | |
| 11. Marital Status
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced | | 12. Was Decedent Ever In U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: White | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12)
12 years | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Yard Manager | | 16b. Kind of Business/Industry
Edrich Lumber Co. | | 17. Father's Name (First, Middle, Last)
Frank S. Barnes | | |
| 18. Mother's Name (First, Middle, Maiden Surname)
Lola Sanders | | 19a. Informant's Name/Relationship (Type, Print)
Richard Stansfield (Guardian) | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
9700 Old Court Rd. Baltimore, MD 21244 | | 20a. Method of Disposition
<input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | |
| 20b. Place of Disposition (Name of cemetery, crematory or other place)
Carroll Cremation, Inc. | | 20c. Date
5-28-96 | | 20d. Location - City or Town, State
Hampstead, MD | | 21. Signature of Funeral Service Licensee
 | | |
| 22. Name and Address of Facility
Loring Byers Funeral Directors, Inc.
8728 Liberty Rd. Randallstown, MD 21133 | | 23a. Part I: Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
a. SEVERE CONGESTIVE CARDIOMYOPATHY
Due to (or as a consequence of):
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d. | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | |
| 28a. Date of injury (Month, Day, Year) | | 28b. Time of injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | | |
| 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier
 | | |
| 29c. License number
D37333 | | 29d. Date signed (Month, Day, Year)
MAY 23, 1996 | | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
C. RAVI MD, NHC, BALTO. MD 21133 | | 31. Date filed (Month, Day, Year)
MAY 29 1996 | | |
| 32. Registrar's Signature
 | | 33. State Registrar
State Registrar | | 34. Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020 | | 35. To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate. | | |

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 15815

| | | | | | | | | |
|---|--|---|--|--|---|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Stanley ADDISON BOYD | | | | 2. Date of Death
Month May Day 27 , Year 1996 | | 3. Time of Death
7:15 PM | |
| | 4a. Facility Name (If not institution, give street and number)
FRANKLIN SQUARE HOS | | | | 4b. City, Town, or Location of Death
BALTO | | 4c. County of Death
Baltimore | |
| Funeral
Director | 5. Social Security Number
217-66-5523 | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday)
39 Yrs. | | 8. Date of Birth (Month, Day, Year)
MAR 2, 1957 | |
| | 10a. State
MD | | 10b. County
N/A | | 10c. City, Town or Location
BALTO | | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | |
| 10e. Street and Number
6004 FRAMINGHAM RD | | | | 10f. Zip Code
21206 | | 10g. Citizen of What Country?
U.S.A. | | |
| 11. Marital Status
<input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc.
Specify BLACK | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 10th College (1-4or 5+) N/A | | | | 18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
GAS STATION ATTENDANT | | | 16b. Kind of Business/Industry
GAS STATION | |
| 17. Father's Name (First, Middle, Last)
PAUL THOMPSON | | | | 18. Mother's Name (First, Middle, Maiden Surname)
EBBIE BOYD | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
EBBIE BOYD | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
6004 FRAMINGHAM RD BALTO, MD 21216 | | | | |
| 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
BALTO, CEM | | Data
MAY 31 96 | | 20c. Location - City or Town, State
BALOT, MD | | |
| 21. Signature of Funeral Service Licensee
 | | | | 22. Name and Address of Facility
BETTS FUNERAL HOME
1129 N. CAROLINE ST BALTO, MD 21213 | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Chronic Renal Failure
Due to (or as a consequence of):

b. Essential Hypertension
Due to (or as a consequence of):

c. Chronic Heroin Abuse
Due to (or as a consequence of):

d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | | |
| Approximate Interval Between Onset and Death
5 Years
5 Years | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | |
| | | | | | | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier
 | | 29c. License number
AF-2328412-1887 | | 29d. Date signed (Month, Day, Year)
5/27/96 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Howard H. Framingham 9000 Franklin Square Dr. Balto, Md. 21237 | | | | | | | | |
| 31. Date filed (Month, Day, Year)
MAY 29 1996 | | 32. Registrar's Signature
 | | | | | | |

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 15816

Certificate of Death

Reg. No.

| | | | | | | | | |
|--|--|--|--|--|--|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
RUTH L BANKS | | | | 2. Date of Death
Month Day Year
MAY 20, 1996 | | 3. Time of Death
11:02 p | |
| | 4a. Facility Name (If not institution, give street and number)
1212 EDISON HIGHWAY | | | | 4b. City, Town, or Location of Death
BALTO | | 4c. County of Death
N/A | |
| Funeral
Director | 5. Social Security Number
218-26-0442 | | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday)
Yrs. 74 | | 8. Date of Birth (Month, Day, Year)
MAY 30, 1921 | |
| | 9. Birthplace (State or Foreign Country)
VA | | 10a. State
MD | | 10b. County
N/A | | 10c. City, Town or Location
BALTO | |
| To Be Completed by Funeral Director | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 10e. Street and Number
1212 EDISON HIGHWAY | | 10f. Zip Code
21213 | | 10g. Citizen of What Country?
U.S.A. | |
| | 11. Marital Status
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: BLACK | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 9th | | 15a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
HOSPITAL ATTENDANT | | 15b. Kind of Business/Industry
HOSPITAL | | | |
| | 16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
HOSPITAL ATTENDANT | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
HOSPITAL | | 16b. Kind of Business/Industry
HOSPITAL | | | |
| | 17. Father's Name (First, Middle, Last)
JAMES JEFFRESS | | 18. Mother's Name (First, Middle, Maiden Surname)
ESTELA HARRIS | | 19a. Informant's Name/Relationship (Type, Print)
RUTH BANKS CROWDER | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
11219A AV COLUMBIA, MD 21044 | |
| | 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
GARRISON FOREST VA CEM | | 20c. Location - City or Town, State
owings mills, md | | | |
| | 21. Signature of Funeral Service Licensee
 | | 22. Name and Address of Facility
BETTS FUNERAL HOME
1129 N. CAROLINE ST. BALTO, MD 21213 | | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
Renal Failure
Due to (or as a consequence of):
Amyloid
Due to (or as a consequence of):
Multiple Myeloma
Due to (or as a consequence of): | | Approximate Interval Between Onset and Death
3 weeks
1 1/2 years
1 year | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
Renal Failure
Due to (or as a consequence of):
Amyloid
Due to (or as a consequence of):
Multiple Myeloma
Due to (or as a consequence of): | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| | 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input checked="" type="checkbox"/> DCA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | |
| | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input type="checkbox"/> No | | 28d. Describe how injury occurred | |
| 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier
 | | |
| 29b. Signature and title of certifier
 | | 29c. License number
L9773 | | 29d. Date signed (Month, Day, Year)
MAY 24 96 | | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Philip G Stein Tower 110 Johns Hopkins Hospital, Balt. MD 21205 | | |
| 31. Date filed (Month, Day, Year)
MAY 29 1996 | | 32. Registrar's Signature
 | | State Registrar | | | | |

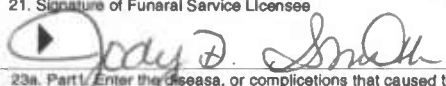
Baltimore, Maryland 21215-0020

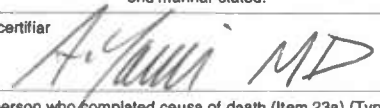

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene
Certificate of Death

96 15817

Reg. No.

| | | | | | | | | | |
|---|---|---------------------------------|---|--|---|---|--|---|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Marion M. BONSAI | | | | | 2. Date of Death
Month May Day 26 Year 1996 | | 3. Time of Death
5:00 am | |
| | 4e. Facility Name (If not institution, give street and number)
Franklin Square Hospital | | | | | 4b. City, Town, or Location of Death
Baltimore | | 4c. County of Death
Baltimore | |
| Funeral
Director | 5. Social Security Number
218-18-6284 | | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)
91 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth (Month, Day, Year)
April 17, 1905 | | 9. Birthplace (State or Foreign Country)
New York |
| | Usual Residence of Decedent | | | | | | | | |
| To Be Completed by Funeral Director | 10a. State
Md. | 10b. County
Baltimore | | 10c. City, Town or Location
Parkville | | | 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| | 10e. Street and Number
2911 Second Ave. | | | | 10f. Zip Code
21234 | | 10g. Citizen of What Country?
U.S.A. | | |
| | 11. Marital Status
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever In U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: White | | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12TH College (1-4or 5+) | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Shipping Clerk | | | 16b. Kind of Business/Industry
Clothing Industry | | |
| | 17. Father's Name (First, Middle, Last)
Charles McDermott | | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Elizabeth Commander | | | |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print)
Mrs. Wilma Borden | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
2911 Second Ave. Baltimore, Md. 21234 | | | | |
| | 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Baltimore Cem. | | Date
5/29 | | 20c. Location - City or Town, State
Baltimore, Md. | | |
| | 21. Signature of Funeral Service Licensee
 | | | | 22. Name and Address of Facility
Hartley Miller Funeral Home
7527 Harford Rd. Baltimore, Md. 21234 | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

<div style="display: flex; justify-content: space-between;"> <div style="width: 80%;"> <p>Immediate Cause (Final disease or condition resulting in death)</p> <p>a. <u>Congestive Heart Failure</u>
Due to (or as a consequence of):</p> <p>b. <u>Chronic Obstructive Pulmonary Disease</u>
Due to (or as a consequence of):</p> <p>c. _____
Due to (or as a consequence of):</p> <p>d. _____</p> </div> <div style="width: 15%; text-align: center;"> <p>10 years</p> </div> </div> | | | | | | | | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | 23b. Did tobacco use contribute to the cause of death?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |
| | | | | | | | | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | 26. Place of Death (Check only one)
Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accidental <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input type="checkbox"/> No | | 28d. Describe how Injury occurred |
| | | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | | |
| 29b. Signature and title of certifier
 | | | | | 29c. License number
D46263 | | 29d. Date signed (Month, Day, Year)
May 26, 1996 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Ayman Youssri M.D. 3333 North Charles Street Baltimore, Maryland 21218 | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
MAY 29 1996
 | | | | | | | | | |

Baltimore, Maryland 21215-0020
 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
 Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,
 To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

**State
Registrar**

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 15818

Certificate of Death

Reg. No.

| | | | | | | | | |
|--|---|--|---|---|---|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
<u>Joseph L Buckley</u> | | | | 2. Date of Death
Month <u>May</u> Day <u>24</u> Year <u>1996</u> | | 3. Time of Death
<u>1343</u> | |
| | 4a. Facility Name (If not institution, give street and number)
<u>Baltimore V.A.M.C.</u> | | | | 4b. City, Town, or Location of Death
<u>Baltimore</u> | | 4c. County of Death
<u>Baltimore City</u> | |
| Funeral
Director | 5. Social Security Number
<u>062 38 2738</u> | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday)
<u>49</u> Yrs. | | 8. Date of Birth (Month, Day, Year)
<u>Nov 16 1946</u> | |
| | 10a. State
<u>Md</u> | | 10b. County
<u>Anne Arundel</u> | | 10c. City, Town or Location
<u>Deale</u> | | 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| Usual Residence of Decedent | | | | | | | | |
| 10e. Street and Number
<u>830 Cedar Drive</u> | | | | 10f. Zip Code
<u>20751</u> | | 10g. Citizen of What Country?
<u>USA</u> | | |
| 11. Marital Status
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | | 12. Was Decedent Ever in U.S. Armed Forces?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
If Yes, Give Year or Dates: <u>1967-1968</u> | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No)
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: <u>White</u> | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) <u>12</u> College (1-4 or 5+) <u>5</u> | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
<u>Contract Negotiator</u> | | 16b. Kind of Business/Industry
<u>US Govt</u> | | |
| 17. Father's Name (First, Middle, Last)
<u>Joseph Daniel Buckley</u> | | | | | 18. Mother's Name (First, Middle, Maiden Surname)
<u>Helen Ward</u> | | | |
| 19a. Informant's Name/Relationship (Type, Print)
<u>Patricia Buckley</u> | | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
<u>830 Cedar Drive, Deale, Md 20751</u> | | | |
| 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
<u>Md Va Cemetery</u> | | Data
<u>5/29/96</u> | | 20c. Location - City or Town, State
<u>Cheltenham, Md</u> | |
| 21. Signature of Funeral Service Licensee
<u>Charles Bannister</u> | | | | | 22. Name and Address of Facility
<u>Hardesty Funeral Home, P.A., 12 Ridgely Ave., Annapolis, Md 21401</u> | | | |
| 23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
<u>multiple organ system failure</u>
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
<u>left ventricular thrombus/embolus</u>
Due to (or as a consequence of):
<u>coronary artery disease</u>
Due to (or as a consequence of):

Approximate Interval Between Onset and Death
<u>3 days</u>
<u>uncertain</u>
<u>years</u> | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown | | |
| | | | | | | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | 28. Place of Death (Check only one)
Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of injury
<u>M</u> | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input type="checkbox"/> No | |
| | | | 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | 28d. Describe how injury occurred | | |
| | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | |
| 29b. Signature and title of certifier
<u>Cynthia D. Helms MD</u> | | | | | 29c. License number
<u>17-10156</u> | | 29d. Date signed (Month, Day, Year)
<u>May 24, 1996</u> | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
<u>Baltimore V.A.M.C. 10 S. Greene St Baltimore MD 21201</u> | | | | | | | | |
| 31. Date filed (Month, Day, Year)
<u>MAY 29 1996</u> | | | 32. Registrar's Signature
<u>[Signature]</u> | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

96 15819

| | | | | | | | | | | | |
|---|--|--|--|--|--|---|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
<i>Minnie McCargo Brown</i> | | | | 2. DATE OF DEATH
MONTH DAY YEAR
<i>May 26, 1996</i> | | | | 3. TIME OF DEATH
<i>8:00 A.M.</i> | | | |
| 4. SOCIAL SECURITY NUMBER
<i>219-18-8821</i> | | 5. SEX
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
<i>72</i> YRS. | | 7. DATE OF BIRTH
(Month, Day, Year)
<i>Sept 15, 1923</i> | | 8. BIRTHPLACE (State or Foreign Country)
<i>Virginia</i> | | | |
| 9a. FACILITY NAME (If not institution, give street and number)
<i>2232 Penrose Avenue</i> | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
<i>Baltimore</i> | | | | 9c. COUNTY OF DEATH
<i>NA</i> | | | |
| 10a. STATE
<i>Maryland</i> | | 10b. COUNTY
<i>NA</i> | | 10c. CITY, TOWN OR LOCATION
<i>Baltimore</i> | | | | 10d. INSIDE CITY LIMITS?
<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | | |
| 10e. STREET AND NUMBER
<i>2232 Penrose Avenue</i> | | | | 10f. ZIP CODE
<i>21223</i> | | 10g. CITIZEN OF WHAT COUNTRY?
<i>U.S.A.</i> | | | | | |
| 11. MARITAL STATUS
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | | | 14. RACE — American Indian, Black, White, etc.
Specify: <i>Black</i> | | | |
| 15. DECEDENT'S EDUCATION
(Specify only highest grade completed)
Elementary/Secondary (0-12) <i>11th</i>
College (1-4 or 5+) <i>N/A</i> | | 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.)
<i>Custodian</i> | | | | 16b. KIND OF BUSINESS/INDUSTRY
<i>Furniture</i> | | | | | |
| 17. FATHER'S NAME (First, Middle, Last)
<i>Wyatt McCargo Brown</i> | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
<i>Helen Dupree</i> | | | | | | | |
| 19a. INFORMANT'S NAME (Type/Print)
<i>Leroy Brown</i> | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
<i>2232 Penrose Ave, Baltimore Md. 21223</i> | | | | | | | |
| 20a. METHOD OF DISPOSITION
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
<i>Cedar Hill May 31/96</i> | | | | 20c. LOCATION — City or Town, State
<i>Baltimore, Md</i> | | | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
<i>Carlton C. Douglas</i> | | | | 22. NAME AND ADDRESS OF FACILITY
<i>Douglas Funeral Service
1701 McCulloh Street, Baltimore, Md. 21217</i> | | | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>ASCVD</i>
a. DUE TO (OR AS A CONSEQUENCE OF):

Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. DUE TO (OR AS A CONSEQUENCE OF):
c. DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
<i>Hypertension</i>

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | | | | Approximate Interval Between Onset and Death
<i>2 yrs</i> | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA
OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. MANNER OF DEATH
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation
<input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined
<input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY
(Month, Day, Year) | | 28b. TIME OF INJURY
M | | 28c. INJURY AT WORK?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | | | |
| 29a. CERTIFIER
(Check only one)
<input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | 29b. SIGNATURE AND TITLE OF CERTIFIER
<i>Beth F. Jones</i> | | | | | | | |
| 29c. LICENSE NUMBER
<i>D 26 256</i> | | | | 29d. DATE SIGNED (Month, Day, Year)
<i>5/28/96</i> | | | | | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
<i>Beth F. Jones MD 700 Washington Blvd Balto MD 21230</i> | | | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
<i>MAY 29 1996</i> | | | | 32. REGISTRAR'S SIGNATURE
<i>Julia Davidson-Randall</i> | | | | | | | |

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

96 15820

Reg. No.

| | | | | | | | | |
|---|--|--|---|--|--|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
WALTER BRADFORD | | | | 2. Date of Death
Month Day Year
MAY 22, 1996 | | 3. Time of Death
0326 AM | |
| | 4a. Facility Name (If not institution, give street and number)
1514 NORTH MOUNT STREET | | | | 4b. City, Town, or Location of Death
BALTIMORE | | 4c. County of Death
BALTIMORE | |
| Funeral
Director | 5. Social Security Number
213-34-0316 | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday)
59 Yrs. | | 8. Date of Birth (Month, Day, Year)
NOV. 5, 1936 | |
| | 9. Birthplace (State or Foreign Country)
MARYLAND | | 10a. State
MARYLAND | | 10b. County
BALTIMORE | | 10c. City, Town or Location
BALTIMORE CITY | |
| To Be Completed by Funeral Director | 10e. Street and Number
1514 NORTH MOUNT STREET | | | | 10f. Zip Code
21217 | | 10g. Citizen of What Country?
USA. | |
| | 11. Marital Status
<input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: BLACK | |
| To Be Completed by Physician/Medical Examiner | 15. Decedent's Education (Specify only highest grade completed)
10th GRADE | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
HOME IMPROVEMENT | | 16b. Kind of Business/Industry
SELF-EMPLOYED | |
| | 17. Father's Name (First, Middle, Last)
WILLIAM BRADFORD | | | | 18. Mother's Name (First, Middle, Maiden Surname)
LOUISE CARTER | | | |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print)
COSTELLA KENT | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1514 NORTH MOUNT STREET, BALTIMORE, MD. 21217 | | | |
| | 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
MT. ZION CEMETERY | | 20c. Location - City or Town, State
5-28-96 BALTIMORE, MARYLAND | | 20d. Date | |
| To Be Completed by Physician/Medical Examiner | 21. Signature of Funeral Service Licensee
 | | | | 22. Name and Address of Facility
JOSEPH H. BROWN JR. FUNERAL HOME: P.A.
2140 N. FULTON AVENUE, BALTIMORE, MD. 21217 | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

<div style="display: flex;"> <div style="flex: 1;"> <p>Immediate Cause (Final disease or condition resulting in death)</p> <p>a. Arteriosclerotic Cardiovascular Disease
Due to (or as a consequence of):</p> <p>b. Due to (or as a consequence of):</p> <p>c. Due to (or as a consequence of):</p> <p>d. Due to (or as a consequence of):</p> </div> <div style="flex: 1;"> <p>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last</p> </div> </div> | | | | | | | |
| To Be Completed by Physician/Medical Examiner | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | |
| | | | | | | | 24a. Was an autopsy performed?
INSPECTION
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| | 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| To Be Completed by Physician/Medical Examiner | 28d. Describe how injury occurred | | | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | |
| | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| To Be Completed by Physician/Medical Examiner | 29a. Certifier (Check only one)
<input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| | 29b. Signature and title of certifier
 | | | | 29c. License number
O.C.M.E | | 29d. Date signed (Month, Day, Year)
MAY 22, 1996 | |
| To Be Completed by Physician/Medical Examiner | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
J. Laron Locke M.D. 111 Penn Street, Baltimore, Maryland 21201 | | | | | | | |
| | 31. Date filed (Month, Day, Year)
MAY 29 1996 | | | | 32. Registrar's Signature
 | | | |

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 96 15821

Certificate of Death

Reg. No.

| | | | | | | | | |
|--|--|--|---|--|--|--|---|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
ARNETTA BALDWIN | | | | 2. Date of Death
Month MAY Day 28 Year 1996 | | 3. Time of Death
11:00 PM | |
| | 4a. Facility Name (If not institution, give street and number)
NorthWest Medical Center | | | | 4b. City, Town, or Location of Death
NA | | 4c. County of Death
Baltimore | |
| Funeral
Director | 5. Social Security Number
577-26-8968 | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)
82 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth
(Month, Day, Year)
3-21-14 | 9. Birthplace (State or Foreign Country)
UNK | |
| | Usual Residence of Decedent | | | | | | | |
| To Be Completed by Funeral Director | 10a. State
MD | 10b. County
NA | 10c. City, Town or Location
BATIMORE | | | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | |
| | 10e. Street and Number
4800 SETON Drive | | | 10f. Zip Code
21215 | | 10g. Citizen of What Country?
MSA | | |
| | 11. Marital Status
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: Black | |
| | 15. Decedent's Education
(Specify only highest grade completed)
Elementary/Secondary (0-12) UNK College (1-4 or 5+) UNK | | 18a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)
UNK | | 16b. Kind of Business/Industry
UNK | | | |
| | 17. Father's Name (First, Middle, Last)
UNK | | | 18. Mother's Name (First, Middle, Maiden Surname)
UNK | | | | |
| Physician
/Medical
Examiner | 19a. Informant's Name/Relationship (Type, Print)
Fred Grant-Guardian | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
861 Park Ave Baltimore, MD 21201 | | | | |
| | 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
MT. ZION | | Date
5-29-96 | 20c. Location - City or Town, State
Lansdowne, MD. | | |
| | 21. Signature of Funeral Service Licensee
 | | | 22. Name and Address of Facility
638 N. Gilman Street Baltimore, MD. 21217 | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
SEPTIS
Due to (or as a consequence of):
Vancomycin-Resistant Enterococcus

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. | | | | | | | Approximate Interval Between Onset and Death
25 days |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
HTN, Aneurysm, NIDDM | | | | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |
| Medical Certification: To Be Completed by Physician/Medical Examiner | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | |
| | 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| | 27. Manner of Death
<input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| | 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| | 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| State Registrar | 29b. Signature and title of certifier
 | | | 29c. License number
044505 | | 29d. Date signed (Month, Day, Year)
MAY 28, 1996 | | |
| | 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)
A. J. IMPERIAL, Jr. - NW He. | | | | | | | |
| 31. Date filed (Month, Day, Year)
MAY 29 1996 | | | | 32. Registrar's Signature
 | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Autopsy Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 15822

| | | | | | | |
|---|---|--|---|--|--------------------------------|---|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
TYRONE CARROLL | | 2. Date of Death
MAY 26 Day 1996 Year | | 3. Time of Death
06:31 AM | |
| | 4a. Facility Name (If not institution, give street and number)
SHOCK TRAUMA UNIT | | 4b. City, Town, or Location of Death
BALTIMORE | | 4c. County of Death
N/A | |
| Funeral
Director | 5. Social Security Number
212-92-8276 | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)
18 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth (Month, Day, Year)
02/26/78 |
| | 9. Birthplace (State or Foreign Country)
MD. | | 10. Usual Residence of Decedent | | | |
| 10a. State
MD | | 10b. County
N/A | | 10c. City, Town or Location
BALTIMORE | | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |
| 10e. Street and Number
3225 BRIGHTON STREET | | 10f. Zip Code
21216 | | 10g. Citizen of What Country?
US | | |
| 11. Marital Status
<input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: BLK. |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 11 Collage (1-4 or 5+) -0- | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
STUDENT | | 16b. Kind of Business/Industry
N/A | | |
| 17. Father's Name (First, Middle, Last)
JEFFERY DAVIS | | 18. Mother's Name (First, Middle, Maiden Surname)
NANCY PRYOR | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
NANCY MIDDLETON (MOTHER) | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
3225 BRIGHTON ST. BALTIMORE, MD. 21216 | | | | |
| 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
WESTERN STAR CEMT. | | 20c. Location - City or Town, State
6/1/96 BALTIMORE, MD. | | |
| 21. Signature of Funeral Service Licensee
<i>[Signature]</i> CFSP #281 | | 22. Name and Address of Facility
PHILLIPS FUNERAL HOME
1721-27 N. MONROE ST. BALTIMORE, MD. 21217 | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediata Cause (Final disease or condition resulting in death)
a. GUNSHOT WOUND OF CHEST ARS.
Dua to (or as a consequence of):

b. Dua to (or as a consequence of):

c. Dua to (or as a consequence of):

d. Sequentially list conditions, if any, leading to immediata causa. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | |
| 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | | | | |
| 24a. Was an autopsy performed?
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death?
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | | |
| 25. Was case referred to medical examiner?
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28. Place of Death (Check only one)
Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | |
| 27. Manner of Death
1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation
2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined
3 <input type="checkbox"/> Suicide 4 <input checked="" type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day, Year)
5/26/96 | | 28b. Time of Injury
0147 hrs | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |
| | | 28d. Describe how injury occurred
SHOT BY ASSAULTANT | | 28e. Location (Street and Number or Rural Route Number, City or Town, State)
600 BLK. W. LEXINGTON ST. | | |
| 29a. Certifier (Check only one)
1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | |
| 29b. Signature and title of certifier
<i>[Signature]</i> | | 29c. License number
O.C.M.E. | | 29d. Date signed (Month, Day, Year)
MAY 26, 1996 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
SMIA LK 111 Penn Street, Baltimore, Maryland 21201 | | | | | | |
| 31. Date filed (Month, Day, Year)
MAY 29 1996 <i>[Signature]</i> | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28c show any injury or other traumatic event, the Medical Examiner must be notified at 900.8.

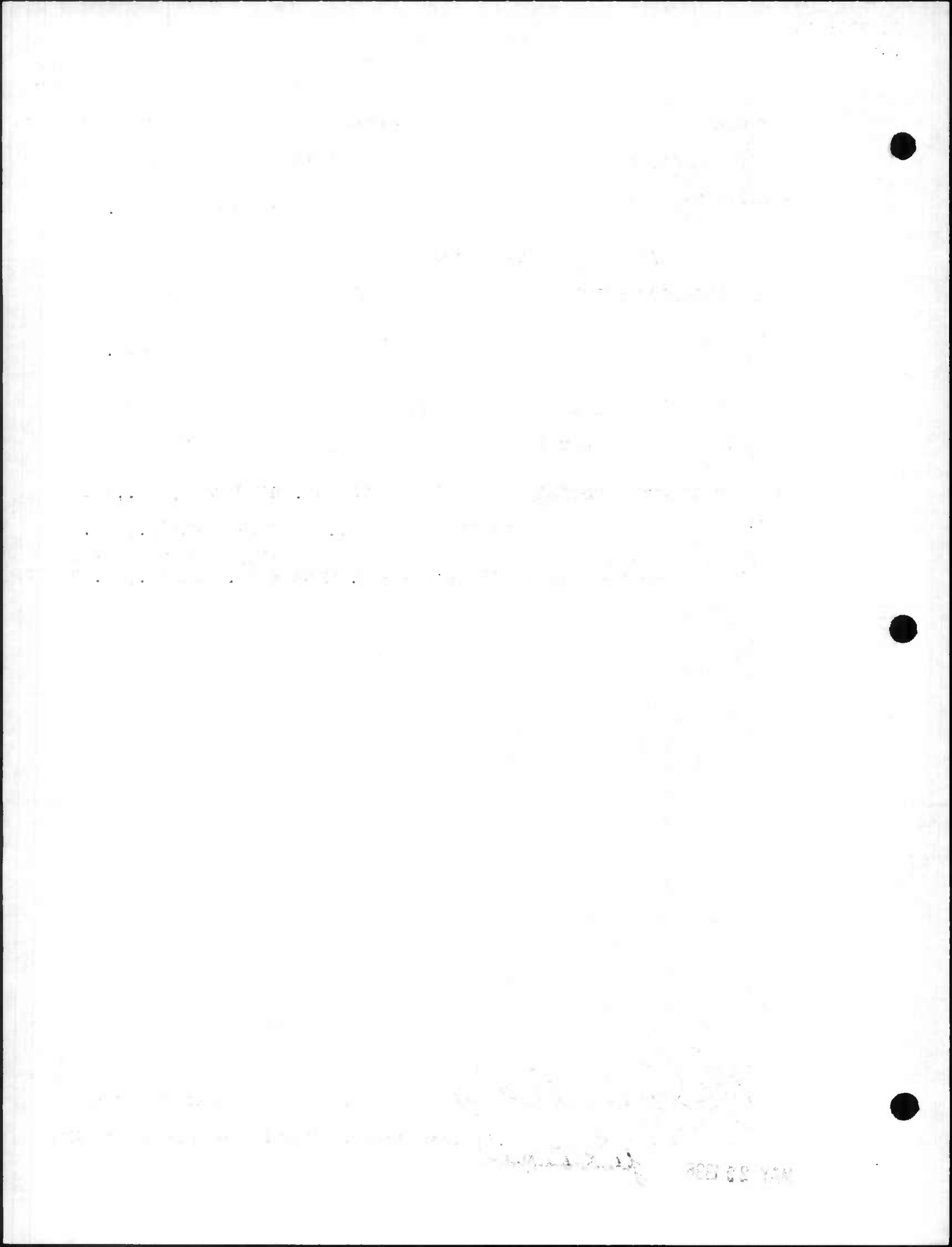
To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 15823

Certificate of Death

Reg. No.

| | | | | | | | | | |
|---|---|---|--|---|---|--|--|---|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Eileen Naomi Corder | | | | 2. Date of Death
Month May Day 27 Year 1996 | | 3. Time of Death
11:40 AM | | |
| | 4a. Facility Name (If not institution, give street and number)
Pikesville Nurseing Center | | | | 4b. City, Town, or Location of Death
Pikesville | | 4c. County of Death
Baltimore | | |
| Funeral
Director | 5. Social Security Number
216-24-6459 | | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday)
69 Yrs. | | 8. Date of Birth (Month, Day, Year)
April 20, 1927 | | |
| | 9. Birthplace (State or Foreign Country)
Maryland | | 10a. State
Maryland | | 10b. County
Baltimore | | 10c. City, Town or Location
Rockdale | | |
| Usual Residence of Decedent | | 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 10e. Street and Number
3603 Kenmar Road | | 10f. Zip Code
21244 | | 10g. Citizen of What Country?
United States | |
| 11. Marital Status
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: Caucasian | | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (1-4or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Housewife | | 16b. Kind of Business/Industry
Home | | 17. Father's Name (First, Middle, Last)
John Blankner | | 18. Mother's Name (First, Middle, Maiden Surname)
Ella Kirk | |
| 19a. Informant's Name/Relationship (Type, Print)
Debra G. Lerner (Daughter) | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
718 Greenwood Rd. Pikesville, Maryland 21208 | | 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Mt. Olive Cemetery May 30, 1996 | | 20c. Location - City or Town, State
Randallstown, Maryland | |
| 21. Signature of Funeral Service Licensee
 | | 22. Name and Address of Facility
Loring Byers Funeral Directors, Inc.
8728 Liberty Rd Randallstown, MD 21133-4784 | | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. Renal Failure
Due to (or as a consequence of):
b. Urinary Retention
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.
Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last | | Approximate Interval Between Onset and Death | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | 27. Manner of Death
1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | |
| 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier
 | | 29c. License number
DD4291 | | 29d. Date signed (Month, Day, Year)
05/28/96 | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Howard J. Garber, M.D. 5310 Old Court Rd Randallstown, MD 21133 | | 31. Date filed (Month, Day, Year)
MAY 29 1996 | | 32. Registrar's Signature
 | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 15824

Certificate of Death

Reg. No.

| | | | | | | | | |
|---|--|--|--|--|---|--|---|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
<u>Clyde Wayne Cavin</u> | | | | 2. Date of Death
Month <u>May</u> Day <u>25th</u> Year <u>96</u> | | 3. Time of Death
<u>2:50 pm</u> | |
| | 4a. Facility Name (If not institution, give street and number)
<u>Harbor Hospital Center, 3001 South Harrower</u> | | | | 4b. City, Town, or Location of Death
<u>Baltimore</u> | | 4c. County of Death
<u>Baltimore City</u> | |
| Funeral
Director | 5. Social Security Number
<u>212 48 1920</u> | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday)
<u>51</u> Yrs. | | 8. Date of Birth (Month, Day, Year)
<u>Aug. 12, 1944</u> | |
| | 9. Birthplace (State or Foreign Country)
<u>Maryland</u> | | 10a. State
<u>Maryland</u> | | 10b. County
<u>Anne Arundel</u> | | 10c. City, Town or Location
<u>Baltimore</u> | |
| To Be Completed by Funeral Director | 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 10e. Street and Number
<u>2 - 15th Avenue</u> | | 10f. Zip Code
<u>21225</u> | |
| | 10g. Citizen of What Country?
<u>U.S.</u> | | | | 11. Marital Status
<input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
If Yes, Give Year or Dates: | |
| To Be Completed by Physician/Medical Examiner | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | | 14. Race - American Indian, Black, White, etc.
Specify: <u>White</u> | | 15. Decedent's Education (Specify only highest grade completed)
<u>12th</u> | |
| | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
<u>Materials Handler</u> | | | | 16b. Kind of Business/Industry
<u>Westinghouse</u> | | 17. Father's Name (First, Middle, Last)
<u>Charles Cavin</u> | |
| To Be Completed by Physician/Medical Examiner | 18. Mother's Name (First, Middle, Maiden Surname)
<u>Effie Johnson</u> | | | | 19a. Informant's Name/Relationship (Type, Print)
<u>John Cavin</u> | | | |
| | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
<u>221 Scotts Manor Drive Glen Burnie, Maryland 21061</u> | | | | 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | |
| To Be Completed by Physician/Medical Examiner | 20b. Place of Disposition (Name of cemetery, crematory or other place)
<u>Glen Haven Memorial Park</u> | | | | 20c. Location - City or Town, State
<u>Glen Burnie, Maryland</u> | | 20d. Date
<u>5/28/96</u> | |
| | 21. Signature of Funeral Service Licensee
<u>Richard Gonce</u> | | | | 22. Name and Address of Facility
<u>Gonce Funeral Home P.A.
4001 Ritchie Highway Baltimore, Md. 21225</u> | | | |
| To Be Completed by Physician/Medical Examiner | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. <u>Multiple Organ Failure</u>
Due to (or as a consequence of):

b. <u>Metastatic Squamous Cell Carcinoma</u>
Due to (or as a consequence of):

c. _____
Due to (or as a consequence of):

d. _____

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | Approximate Interval Between Onset and Death

<u>1 month</u>

<u>1 year</u> | | | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | | |
| To Be Completed by Physician/Medical Examiner | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No | | | |
| | 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one)
Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | |
| To Be Completed by Physician/Medical Examiner | 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | | | 28a. Date of injury (Month, Day Year) | | 28b. Time of injury M | |
| | 28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | 28d. Describe how injury occurred | | 28e. Location (Street and Number or Rural Route Number, City or Town, State) | |
| To Be Completed by Physician/Medical Examiner | 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | 29b. Signature and title of certifier
<u>Changjian Chen, MD</u> | | | |
| | 29c. License number
<u>AS 2441614-43</u> | | | | 29d. Date signed (Month, Day, Year)
<u>May 25th, 1996</u> | | | |
| To Be Completed by Physician/Medical Examiner | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
<u>Changjian Chen, 7888 Americana Circle #101, Glen Burnie, MD 21060</u> | | | | 31. Date filed (Month, Day, Year)
<u>MAY 29 1996</u> | | | |
| | 32. Registrar's Signature
<u>Julia David-Randall</u> | | | | | | | |

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 15825

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Mark Anthony Cvitkovich

2. Date of Death

Month Day Year
May 27, 1996

3. Time of Death

23:46 p.m.

Funeral
Director

4a. Facility Name (If not institution, give street and number)

Sinai Hospital

4b. City, Town, or Location of Death

Baltimore City

4c. County of Death

Baltimore City

5. Social Security Number

312 - 05 - 1191

6. Sex

XX ☒ M ☐ F

7. Age (In yrs. last birthday)

84 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Nov. 19, 1911

9. Birthplace (State or Foreign Country)

Chicago, Ill.

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Reisterstown

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

513 Glen Granite Road

10f. Zip Code

21136

10g. Citizen of What Country?

U.S.A.

11. Marital Status

☐ Never Married ☒ Married
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
☐ Yes ☒ No
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)☐ Yes ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
-6-College (1-4 or 5+)
-0-16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Chief Engineer

16b. Kind of Business/Industry

Hotel

17. Father's Name (First, Middle, Last)

Joseph Cvitkovich

18. Mother's Name (First, Middle, Maiden Surname)

Josephine Kazum

19a. Informant's Name/Relationship (Type, Print)

Joan Clavin - Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

513 Glen Granite Rd. - Reisterstown, Md. - 21136

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State
☐ Donation ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Calumet Park Cemetery

Date

5-31-96

20c. Location - City or Town, State

Merrillville, Indiana

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Eline Funeral Home 11824 Reisterstown Road
Reisterstown, Maryland 21136Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)a. Pneumonia
Due to (or as a consequence of):Approximate
Interval Between
Onset and DeathOne monthSequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or Injury
that initiated events
resulting in death) Lastb.
Due to (or as a consequence of):c.
Due to (or as a consequence of):d.
Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

CVAprosthetic heart valve

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown24a. Was an autopsy
performed?☐ Yes ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?☐ Yes ☒ No25. Was case referred to medical
examiner?☐ Yes ☒ No

Hospital:

☐ Inpatient ☒ ER/Outpatient ☐ DOA

Other:

☐ Nursing Home ☒ Residence ☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending
Investigation
☐ Accident ☐ Could not be
determined
☐ Suicide ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of
Injury

M

28c. Injury at
Work?☐ Yes ☒ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D27869

29d. Date signed (Month, Day, Year)

5/29/96

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Allen Bettelman 1777 Reisterstown Rd #365

31. Date filed (Month, Day, Year)

MAY 29 1996

32. Registrar's Signature

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

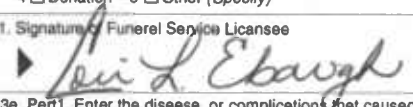
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

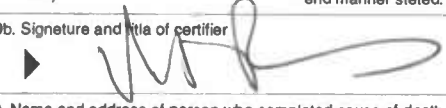
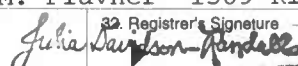
96 15826

Certificate of Death

Reg. No.

| | | | | | | | | | | | | | |
|--|--|--|---|---|--|--------------------------------|--|--|--|---|---|---|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Dorothy E. Chambers | | | | | | 2. Date of Death
Month Day Year
May 24, 1996 | | | 3. Time of Death
1:13 A.M. | | | |
| | 4a. Facility Name (If not institution, give street and number)
North Arundel Hospital | | | | | | 4b. City, Town, or Location of Death
Glen Burnie | | | 4c. County of Death
Anne Arundel | | | |
| Funeral
Director | 5. Social Security Number
212-22-3949 | | 6. Sex
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)
72 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth (Month, Day, Year)
Nov. 4, 1923 | | 9. Birthplace (State or Foreign Country)
Maryland | | | | |
| | Usual Residence of Decedent | | | | | | | | | | | | |
| To Be Completed by Funeral Director | 10a. State
Maryland | | 10b. County
Baltimore City | | 10c. City, Town or Location
Baltimore | | | | 10d. Inside City Limits
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | |
| | 10e. Street and Number
1305 Church Street | | | | 10f. Zip Code
21226 | | | 10g. Citizen of What Country?
United States | | | | | |
| | 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc.
Specify: White | | | | | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 7 College (1-4 or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Teachers Assistant | | | 16b. Kind of Business/Industry
Education | | | | | |
| | 17. Father's Name (First, Middle, Last)
Charles E. Barnes | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Mary Marie Wachter | | | | | | | | |
| | 19a. Informant's Name/Relationship (Type, Print)
Donna L. Bennett | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
133 Foxwell Blvd., Glen Burnie, Maryland 21061 | | | | | | | | |
| | 20a. Method of Disposition
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Glen Haven Mem. Pk. May 28, 1996 | | Data | | 20c. Location - City or Town, State
Glen Burnie, Maryland | | | | | | |
| | 21. Signature of Funeral Service Licensee
 | | | | 22. Name and Address of Facility
Kirkley-Ruddick Funeral Home
421 Crain Hwy., S.E., Glen Burnie, MD 21061 | | | | | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
e. CAD
Due to (or as a consequence of):
b. DM
Due to (or as a consequence of):
c. HSP
Due to (or as a consequence of):
d.

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last | | | | | | | | | | Approximate Interval Between Onset and Death | | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | | | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | |
| | | | | | | | | | | 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| Medical Certification: To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | | | | |
| | 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide
5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | | | | |
| | | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | |
| | 29a. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | | | | | |
| State Registrar | 29b. Signature and Title of certifier
 | | | | 29c. License number
D28686 | | | 29d. Date signed (Month, Day, Year)
May 24, 1996 | | | | | |
| | 30. Name and address of person who completed cause of death (item 23a) (Type, Print)
Dr. Victor M. Plavner 1509 Ritchie Highway Arnold, MD 21012 | | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
MAY 29 1996 | | 32. Registrar's Signature
 | | | | | | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 15827

Certificate of Death

Reg. No.

| | | | | | | | | |
|--|---|--|---|---|--|--------------------------------|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
<i>Theodore R. Crenshaw Sr.</i> | | | | 2. Date of Death
Month <i>MAY</i> Day <i>27</i> Year <i>1996</i> | | 3. Time of Death
<i>5:30 p.m.</i> | |
| | 4a. Facility Name (If not institution, give street and number)
<i>BALTIMORE VAMC</i> | | | | 4b. City, Town, or Location of Death
<i>BALTIMORE</i> | | 4c. County of Death
<i>BALTIMORE</i> | |
| Funeral
Director | 5. Social Security Number
<i>218-05-0985</i> | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)
<i>101</i> Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth (Month, Day, Year)
<i>12-25-1894</i> | 9. Birthplace (State or Foreign Country)
<i>TX.</i> |
| | Usual Residence of Decedent | | | | | | | |
| To Be Completed by Funeral Director | 10a. State
<i>MD</i> | | 10b. County
<i>NA</i> | | 10c. City, Town or Location
<i>BALTIMORE</i> | | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | |
| | 10e. Street and Number
<i>2331 Ashburton Street</i> | | | | 10f. Zip Code
<i>21216</i> | | 10g. Citizen of What Country?
<i>USA</i> | |
| | 11. Marital Status
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: <i>1918-1919</i> | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: <i>BLACK</i> | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) <i>5th</i> College (1-4 or 5+) <i>NA</i> | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
<i>COOK</i> | | 16b. Kind of Business/Industry
<i>Ship</i> | | | |
| Physician
/Medical
Examiner | 17. Father's Name (First, Middle, Last)
<i>Sylvester Crenshaw</i> | | | | 18. Mother's Name (First, Middle, Maiden Surname)
<i>Irene Crenshaw</i> | | | |
| | 19a. Informant's Name/Relationship (Type, Print)
<i>Theodore R. Crenshaw, Son Jr.</i> | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
<i>2331 Ashburton St. Baltimore, MD 21216</i> | | | |
| | 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
<i>Garrison Forest Uet</i> | | 20c. Location - City or Town, State
<i>5-31-96 OWINGS MILLS, MD.</i> | | 20d. Date | |
| | 21. Signature of Funeral Service Licensee
<i>[Signature]</i> | | 22. Name and Address of Facility
<i>Albert P. Wylie 638 N. Gilmer Street Baltimore, MD 21217</i> | | | | | |
| Physician
/Medical
Examiner | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. <i>ACUTE EXACERBATION OF CHRONIC LUNG DISEASE</i> 7 days
Dua to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.
Dua to (or as a consequence of):
c.
Dua to (or as a consequence of):
d.
Approximate Interval Between Onset and Death | | | | | | | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | |
| | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown | | | | | | | |
| | 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | |
| Medical Certification: To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| | 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation
2 <input type="checkbox"/> Accident 8 <input type="checkbox"/> Could not be determined
3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| | 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28d. Describe how injury occurred | | | | | |
| | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | 28e. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| State
Registrar | 29a. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| | 29b. Signature and title of certifier
<i>Michael V. Woodbridge MD</i> | | 29c. License number
<i>P07709</i> | | 29d. Date signed (Month, Day, Year)
<i>MAY 27, 1996</i> | | | |
| | 30. Name and address of person who completed cause of death (Item 28a) (Type, Print)
<i>MICHAEL V. WOODBRIDGE, MD 10 North Greene St, BALTIMORE, MD 21201</i> | | | | | | | |
| | 31. Date filed (Month, Day, Year)
<i>MAY 29 1996</i> | | 32. Registrar's Signature
<i>[Signature]</i> | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 15828

Certificate of Death

Reg. No.

| | | | | | | | | |
|---|--|---|---|-------------------------------|---|--|---|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
DARRYL KEVIN COOPER SR. | | | | 2. Date of Death
Month 05 Day 20 Year 96 | | 3. Time of Death
11:30 pm | |
| | 4a. Facility Name (If not institution, give street and number)
Seton Hill Manor | | | | 4b. City, Town, or Location of Death
Baltimore | | 4c. County of Death
BALTIMORE | |
| Funeral
Director | 5. Social Security Number
215-86-2281 | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday)
32 Yrs. | | 8. Date of Birth (Month, Day, Year)
3/26/64 | |
| | 9. Birthplace (State or Foreign Country)
Baltimore | | 10a. State
MD | | 10b. County
BALTIMORE | | 10c. City, Town or Location
Baltimore City | |
| To Be Completed by Funeral Director | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 10e. Street and Number
3408 Alto Road | | 10f. Zip Code
21216 | | 10g. Citizen of What Country?
USA | |
| | 11. Marital Status
<input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: AA | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12TH GRADE | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
UNEMPLOYED | | 16b. Kind of Business/Industry
N/A | | | |
| | 17. Father's Name (First, Middle, Last)
DAVID JOSEPH COOPER JR. | | 18. Mother's Name (First, Middle, Maiden Surname)
VERDELL DAVIS | | 19a. Intendant's Name/Relationship (Type, Print)
VERDELL COOPER | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
4383 CREST HEIGHTS RD. BALTIMORE, MD. 21215 | |
| | 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
ARBUTUS CEMETERY | | 20c. Location - City or Town, State
5-24-96 ARBUTUS, MD. | | | |
| | 21. Signature of Funeral Service Licensee
 | | 22. Name and Address of Facility
JOSEPH H. BROWN JR. FUNERAL HOME, P.A.
2140 N. FULTON AVE, BALTIMORE, MD. 21217 | | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
Progressive Dementia | | Approximate Interval Between Onset and Death
1 year | |
| | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | |
| | 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year)
NONE | |
| | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | | 28e. Location (Street and Number or Rural Route Number, City or Town, State) | |
| | 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier
Robert Kent, MD | | 29c. License number
D06966 | | 29d. Date signed (Month, Day, Year)
5/21/96 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Robert Kent, MD, 1001 N. Calhoun ST Balto. 21201 | | 31. Date filed (Month, Day, Year)
MAY 29 1996 | | 32. Registrar's Signature
 | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Filmg, 735, item #10e,10f, 5/29/96, cvr, per fh

Certificate of Death

Reg. No.

96 15829

| | | | | | | | | | | | | | | | | | | | | |
|---|--|--|---|---|--|--|---|---|---|----|---------------------------------|----------------------------------|----|--|----------------------------------|----|--|----------------------------------|----|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
ZOFIA DUL | | | | 2. Date of Death
Month MAY Day 26 Year 1996 | | 3. Time of Death
1:05 AM | | | | | | | | | | | | | |
| | 4a. Facility Name (If not institution, give street and number)
Church Home Nsg Ctr. | | | | 4b. City, Town, or Location of Death
Baltimore City | | 4c. County of Death
N/A | | | | | | | | | | | | | |
| Funeral
Director | 5. Social Security Number
213-30-8078 | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)
81 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth
(Month, Day, Year)
Oct. 1, 1914 | | 9. Birthplace (State or Foreign Country)
Poland | | | | | | | | | | | | |
| | Usual Residence of Decedent | | | | | | | | | | | | | | | | | | | |
| To Be Completed by Funeral Director | 10a. State
MD | 10b. County
N/A | 10c. City, Town or Location
Baltimore City | | | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | | | | | | | | |
| | 10e. Street and Number
2447 E. JEFFERSON ST. | | | 10f. Zip Code
21224 | | 10g. Citizen of What Country?
U.S. | | | | | | | | | | | | | | |
| | 11. Marital Status
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: W | | | | | | | | | | | | | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 6th College (1-4 or 5+) N/A | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Assembly Line | | 16b. Kind of Business/Industry
Curtain Factory | | | | | | | | | | | | | | |
| | 17. Father's Name (First, Middle, Last)
Walenty Krol | | | 18. Mother's Name (First, Middle, Maiden Surname)
Julia Unknown | | | | | | | | | | | | | | | | |
| | 19a. Informant's Name/Relationship (Type, Print)
Mrs. Jadwiga D. Hodges | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1519 Baldwin Mill Rd. Jarrettsville, Md. 21084 | | | | | | | | | | | | | | | | |
| | 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Parkwood Cemetery | | Date
5/29 | | 20c. Location - City or Town, State
Baltimore, Md. | | | | | | | | | | | | | |
| | 21. Signature of Funeral Service Licensee
<i>[Signature]</i> | | | 22. Name and Address of Facility
Hartley Miller Funeral Home
7527 Harford Rd. Baltimore, Md. 21234 | | | | | | | | | | | | | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | | | | | | | | | | | | | |
| | <table border="0"> <tr> <td rowspan="4"> Immediate Cause (Final disease or condition resulting in death)

 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last </td> <td>a.</td> <td>Cerebrovascular accident</td> <td>Due to (or as a consequence of):</td> </tr> <tr> <td>b.</td> <td></td> <td>Due to (or as a consequence of):</td> </tr> <tr> <td>c.</td> <td></td> <td>Due to (or as a consequence of):</td> </tr> <tr> <td>d.</td> <td></td> <td>Due to (or as a consequence of):</td> </tr> </table> | | | | | | | | Immediate Cause (Final disease or condition resulting in death)

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | a. | Cerebrovascular accident | Due to (or as a consequence of): | b. | | Due to (or as a consequence of): | c. | | Due to (or as a consequence of): | d. | |
| Immediate Cause (Final disease or condition resulting in death)

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | a. | Cerebrovascular accident | Due to (or as a consequence of): | | | | | | | | | | | | | | | | | |
| | b. | | Due to (or as a consequence of): | | | | | | | | | | | | | | | | | |
| | c. | | Due to (or as a consequence of): | | | | | | | | | | | | | | | | | |
| | d. | | Due to (or as a consequence of): | | | | | | | | | | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | | | | | | | | | | |
| | | | | | | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | | | | | | | |
| | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | | | | | | | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | | | | | | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | | | | | | | |
| | | 28d. Describe how Injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | | | | | | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | | | | | | | | | | | | | |
| 29b. Signature and title of certifier
<i>[Signature]</i> MD | | | | 29c. License number
D45280 | | 29d. Date signed (Month, Day, Year)
5/26/96 | | | | | | | | | | | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
SAJJAD MALICK, 100 N. Broadway St. Baltimore, MD | | | | | | | | | | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
MAY 29 1996 | | | | 32. Registrar's Signature
<i>[Signature]</i> | | | | | | | | | | | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Registrar for Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

96 15830

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
Kenneth J. Dower | | | | 2. DATE OF DEATH
MONTH MAY DAY 21 YEAR 1996 | | 3. TIME OF DEATH
10:00 A.M. | |
| 4. SOCIAL SECURITY NUMBER
212-06-3898 | | 5. SEX
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
12 YRS. | | 7. DATE OF BIRTH (Month, Day, Year)
FEB 2, 1984 | |
| 9a. FACILITY NAME (If not institution, give street and number)
Union Memorial Hospital | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
Baltimore City | | 9c. COUNTY OF DEATH
N/A | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE
MD | | 10b. COUNTY
N/A | | 10c. CITY, TOWN OR LOCATION
BALTIMORE | | 10d. INSIDE CITY LIMITS?
<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER
3738 ELLERSLIE AVE | | | | 10f. ZIP CODE
21218 | | 10g. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 11. MARITAL STATUS
<input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR OATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify: BLACK | |
| 15. DECEDENT'S EDUCATION
(Specify only highest grade completed)
Elementary/Secondary (0-12) 6th College (1-4 or 5+) N/A | | 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.)
STUDENT | | 16b. KIND OF BUSINESS/INDUSTRY
N/A | | | |
| 17. FATHER'S NAME (First, Middle, Last)
MELVIN DOWER | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
MARILYN THOMAS | | | |
| 19a. INFORMANT'S NAME (Type/Print)
MELVIN DOWER/FATHER | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
3738 ELLERSLIE AVE BALTO, MD 21218 | | | |
| 20a. METHOD OF DISPOSITION
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
WOODLAWN CEM MAY 25, 96 | | 20c. LOCATION — City or Town, State
WOODLAWN, MD | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
<i>Patricia Betts</i> | | | | 22. NAME AND ADDRESS OF FACILITY
BETTS FUNERAL HOME
1129 N. CAROLINE ST BALTO, MD 21213 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → CEREBRAL HYPOXIA | | | | | | | |
| a. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| b. ASTHMA EXACERBATION | | | | | | | |
| c. ASTHMA | | | | | | | |
| d. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| Approximate interval Between Onset and Death
4 DAYS
4 DAYS
12 yrs | | | | | | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
NONE | | | | | | | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M | | 28c. INJURY AT WORK?
<input type="checkbox"/> YES <input type="checkbox"/> NO | |
| 28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28e. DESCRIBE HOW INJURY OCCURRED | | | |
| 29a. CERTIFIER (Check only one)
1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
<i>Richard Lanson MD</i> | | | | 29c. LICENSE NUMBER
AV4176435AL3065 | | 29d. DATE SIGNED (Month, Day, Year)
MAY 21, 1996 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
RICHARD LANSON UNION MEMORIAL HOSP 201 E. UNIVERSITY PARKWAY, BALTIMORE | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
MAY 29 1996 | | | | 32. REGISTRAR'S SIGNATURE
<i>Richard Lanson</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 15831

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

STEWART J. DUNN

2. Date of Death

MAY 23 1996

3. Time of Death

10:05 a

4a. Facility Name (If not institution, give street and number)

GOOD SAMARITAN HOSPITAL

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

N/A

Funeral
Director

5. Social Security Number

215-09-6911

6. Sex

1 ☒ M 2 ☐ F

7. Age (in yrs. last birthday)

88

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

06-30-1996

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MD.

10b. County

N/A

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

3700 MONTEREY RD.

10f. Zip Code

21218

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

LIFE INSURANCE

16b. Kind of Business/Industry

INSURANCE SALES

17. Father's Name (First, Middle, Last)

WILLIAM E. DUNN

18. Mother's Name (First, Middle, Maiden Surname)

MARY CARRICK

19a. Informant's Name/Relationship (Type, Print)

STEWART K. DUNN

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

313 PRESWAY RD. TIMONIUM, MD. 21093.

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

PARKWOOD CEMETERY

Date

5/28/96

20c. Location - City or Town, State

PARKVILLE, MD.

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

HENRY W. JENKINS & SONS CO.

4905 YORK RD. BALTO., MD. 21212.

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. Neck injury & complications

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Heart Failure

Renal Failure

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural2 ☒ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending Investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

4-3-96

28b. Time of Injury

A.M.

28c. Injury at Work?

1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

Fell down stairs

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Home

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Baltimore

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

A-44728

29d. Date signed (Month, Day, Year)

5-24-96

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MITCHELL SCHWARTZ M.D. 5601 LOCH RAVEN BLVD. BALTO., MD.

31. Date filed (Month, Day, Year)

MAY 29 1996

32. Registrar's Signature

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

is the hospital or attending physician: The law requires that the death certificate be executed within hours after death. If the funeral director, after this certificate has been signed by the attending physician and is not to be filed in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

15

State
Registrar

96 15832

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
James Michael Dalton | | | | 2. DATE OF DEATH
MONTH DAY YEAR
May 25 1996 | | 3. TIME OF DEATH
8:40 A M | |
| 4. SOCIAL SECURITY NUMBER
111-12-8480 | | 5. SEX
1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
84 YRS. | | 7. DATE OF BIRTH (Month, Day, Year)
4-7-1912 | |
| 8. BIRTHPLACE (State or Foreign Country)
Pennsylvania | | | | 9a. FACILITY NAME (If not institution, give street and number)
12100 Cedarbrook Lane | | 9b. CITY, TOWN OR LOCATION OF DEATH
Laurel | |
| 9c. COUNTY OF DEATH
Prince George | | | | 10a. STATE
Maryland | | 10b. COUNTY
Prince George | |
| 10c. CITY, TOWN OR LOCATION
Laurel | | | | 10d. INSIDE CITY LIMITS?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 10e. STREET AND NUMBER
12100 Cedarbrook Lane | |
| 10f. ZIP CODE
20708 | | | | 10g. CITIZEN OF WHAT COUNTRY?
USA | | 11. MARITAL STATUS
1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO
IF YES, GIVE WAR OR DATES
WW II | | | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify:
White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (1-4 or 5+) 4 | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
Manufacturer's Representative | | 16b. KIND OF BUSINESS/INDUSTRY
Men's Accessories | |
| 17. FATHER'S NAME (First, Middle, Last)
Maurice Dalton | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Maude King | | | |
| 19a. INFORMANT'S NAME (Type/Print)
Janice S. Dalton | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
12100 Cedarbrook Lane Laurel, Maryland 20708 | | | |
| 20a. METHOD OF DISPOSITION
1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
Baltimore Washington Crem. 5/25 | | 20c. LOCATION — City or Town, State
Laurel, Maryland | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
 | | | | 22. NAME AND ADDRESS OF FACILITY
Fleck Funeral Home, Inc.
7601 Sandy Spring Road Laurel, MD 20707 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → <u>PANCREATIC CARCINOMA</u> | | | | | | | |
| DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | |
| DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | | | | |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | | | | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA
OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | |
| 27. MANNER OF DEATH
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation
2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined
3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide | | | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M | |
| 28c. INJURY AT WORK?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. CERTIFIER (Check only one)
1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
 | | | | 29c. LICENSE NUMBER
D24997 | | 29d. DATE SIGNED (Month, Day, Year)
5/25/96 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
LUIS A. CASAS M.D. 8317 CHERRY LANE LAUREL MD 20707 | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
MAY 29 1996 | | | | 32. REGISTRAR'S SIGNATURE
 | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

72+1

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 15833

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Emma Marion Daffer

2. Date of Death

Month Day Year
May 25, 1996

3. Time of Death

10:20 P.M.

Funeral
Director

4a. Facility Name (If not institution, give street and number)

319 Laurel Avenue

4b. City, Town, or Location of Death

Laurel

4c. County of Death

Prince George

5. Social Security Number

570-32-8743

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

82 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

Aug. 12, 1913

9. Birthplace (State or Foreign Country)

California

Usual Residence of Decedent

10a. State

MD

10b. County

Prince George

10c. City, Town or Location

Laurel

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

319 Laurel Avenue

10f. Zip Code

20707

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

8

College (1-4 or 5+)

0

18e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

William Carl Ahlborn

18. Mother's Name (First, Middle, Maiden Surname)

Georgiemay Heppeler Ahlborn

19e. Informant's Name/Relationship (Type, Print)

Daniel Irving Daffer/Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

P.O. Box 459, Pahrump, Nevada 89041

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory, or other place)

Pahrump Community Cem.

Date

5/31

20c. Location - City or Town, State

Pahrump, NV

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Fleck Funeral Home, Inc.

7601 Sandy Spring Road, Laurel, Maryland 20707

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Metastatic Renal Carcinoma

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending Investigation 6 ☐ Could not be determined

28e. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29e. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

D24997

29d. Date signed (Month, Day, Year)

5/28/96

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

LUIS A. CASAS M.D. 8317 CHERRY LANE LAUREL MD 20707

31. Date filed (Month, Day, Year)

MAY 29 1996

32. Registrar's Signature

John Davidson-Randall

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

The first part of the paper is devoted to a discussion of the
 general principles of the theory of the structure of the
 crystal lattice. It is shown that the structure of the
 crystal lattice is determined by the nature of the
 chemical bonds between the atoms. The nature of the
 chemical bonds is determined by the electronic structure
 of the atoms. The electronic structure of the atoms is
 determined by the number of electrons and the arrangement
 of the electrons in the atomic orbitals. The arrangement
 of the electrons in the atomic orbitals is determined by
 the Pauli exclusion principle and the Coulomb repulsion
 between the electrons. The Pauli exclusion principle
 states that no two electrons can occupy the same
 atomic orbital. The Coulomb repulsion between the
 electrons tends to keep the electrons as far apart as
 possible. The balance between the Pauli exclusion
 principle and the Coulomb repulsion determines the
 arrangement of the electrons in the atomic orbitals.
 The arrangement of the electrons in the atomic orbitals
 determines the nature of the chemical bonds between the
 atoms. The nature of the chemical bonds between the
 atoms determines the structure of the crystal lattice.

The second part of the paper is devoted to a discussion of the
 specific properties of the crystal lattice. It is shown that the
 specific properties of the crystal lattice are determined by the
 nature of the chemical bonds between the atoms. The nature of the
 chemical bonds between the atoms is determined by the electronic
 structure of the atoms. The electronic structure of the atoms is
 determined by the number of electrons and the arrangement of the
 electrons in the atomic orbitals. The arrangement of the electrons
 in the atomic orbitals is determined by the Pauli exclusion principle
 and the Coulomb repulsion between the electrons. The Pauli exclusion
 principle states that no two electrons can occupy the same atomic
 orbital. The Coulomb repulsion between the electrons tends to keep
 the electrons as far apart as possible. The balance between the Pauli
 exclusion principle and the Coulomb repulsion determines the
 arrangement of the electrons in the atomic orbitals. The arrangement
 of the electrons in the atomic orbitals determines the nature of the
 chemical bonds between the atoms. The nature of the chemical bonds
 between the atoms determines the structure of the crystal lattice.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 15834

Certificate of Death

Reg. No.

| | | | | | | | | |
|--|---|--|---|---|---|---|---|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
JAMES E. DIGGS | | | | 2. Date of Death
Month MAY Day 26 Year 1996 | | 3. Time of Death
7:12AM | |
| | 4a. Facility Name (If not institution, give street and number)
SINAI HOSPITAL OF BALTIMORE | | | | 4b. City, Town, or Location of Death
BALTIMORE, MD | | 4c. County of Death
BALTIMORE | |
| Funeral
Director | 5. Social Security Number
220-24-3835 | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)
66 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth (Month, Day, Year)
JUNE 22, 1929 | 9. Birthplace (State or Foreign Country)
MARYLAND |
| | Usual Residence of Decedent | | | | | | | |
| To Be Completed by Funeral Director | 10a. State
MARYLAND | | 10b. County
BALTIMORE | | 10c. City, Town or Location
BALTIMORE CITY | | | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |
| | 10e. Street and Number
2510 KEYWORTH AVENUE | | | | 10f. Zip Code
21215 | | 10g. Citizen of What Country?
USA | |
| | 11. Marital Status
<input type="checkbox"/> Navar Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: BLACK | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 8TH GRADE | | College (1-4 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
ASSEMBLY LINE WORKER GENERAL MOTORS | | 16b. Kind of Business/Industry | |
| | 17. Father's Name (First, Middle, Last)
ANDREW WILSON | | | | 18. Mother's Name (First, Middle, Maiden Surname)
ELIZABETH DIGGS | | | |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print)
OMIE DIGGS | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
2510 KEYWORTH AVE, BALTIMORE, MD. 21215 | | | |
| | 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
WOODLAWN CEMETERY 5-30-96 WOODLAWN, MD. | | Date | | 20c. Location - City or Town, State | |
| | 21. Signature of Funeral Service Licensee
 | | | | 22. Name and Address of Facility
JOSEPH H. BROWN JR. FUNERAL HOME, P.A.
2140 N. FULTON AVE, BALTIMORE, MD. 21217 | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

<div style="display: flex; justify-content: space-between;"> <div> <p>Immediata Causa (Final disease or condition resulting in death)</p> <p>Sequitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last</p> </div> <div> <p>a. CARDIOGENIC SHOCK</p> <p>Due to (or as a consequence of):</p> <p>b. CORONARY ARTERY DISEASE</p> <p>Due to (or as a consequence of):</p> <p>c. HYPERTENSION</p> <p>Due to (or as a consequence of):</p> <p>d.</p> </div> </div> | | | | | | | |
| | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | | | | | | |
| 24a. Was an autopsy performed?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
TYPE II Diabetes | | | | | | | | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one)
Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input type="checkbox"/> No | | 28d. Describe how injury occurred |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | 29b. Signature and title of certifier
M. Boursiquot, MD | | 29c. License number
AS2402321MB9812 | | 29d. Date signed (Month, Day, Year)
MAY 26, 1996 |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
M. BOURSQUOT, MD SINAI HOSPITAL OF BALTIMORE | | | | | | | | |
| 31. Date filed (Month, Day, Year)
MAY 29 1996 | | | | 32. Registrar's Signature
 | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 96 15835

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

THOMAS A. FRENCH

2. Date of Death

MAY 25 1996

3. Time of Death

11:10 PM

4a. Facility Name (If not institution, give street and number)

HOWARD COUNTY GENERAL HOSPITAL

4b. City, Town, or Location of Death

Columbia

4c. County of Death

Howard

Funeral
Director

5. Social Security Number

219-10-2129

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

89

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

FEB. 19, 1907

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Md.

10b. County

Howard

10c. City, Town or Location

Elkridge

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

5290 Landing Road

10f. Zip Code

21227

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: white

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

8

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Caretaker

16b. Kind of Business/Industry

Sisters of Notre Dame

17. Father's Name (First, Middle, Last)

Thomas J. French

18. Mother's Name (First, Middle, Maiden Summa)

Lorretta Hartzell

19a. Informant's Name/Relationship (Type, Print)

Thomas J. French - son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

5801 Bellanca Drive, Elkridge, Md. 21227

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Meadowridge Memorial Park

Date

5/29/96

20c. Location - City or Town, State

Elkridge, Md.

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Gary L. Kaufman Funeral Home of Elk., Inc.

5695 Main St., Elkridge, Md. 21227

23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. SEPSIS

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

1 DAY

b. CHOLECYSTITIS

Due to (or as a consequence of):

2 DAYS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

c.

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

DEHYDRATION, RENAL INSUFFICIENCY, CHRONIC

BLADDER OUTLET OBSTRUCTION, PROSTATE CANCER

CORONARY ARTERY DISEASE, AORTIC STENOSIS

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending Investigation6 ☐ Could not be determined

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier
(Check only one)2 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

038296

29d. Date signed (Month, Day, Year)

MAY 26, 1996

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

JOSEPH GIBBONS, MD 9501 OLD ANNAPOLIS RD, ELLICOTT CITY, MD 21042

31. Date filed (Month, Day, Year)

MAY 29 1996

32. Registrar's Signature

[Signature]

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 15836

Item: 20c per F.H. G-735 5/29/96 reb

Certificate of Death

Reg. No.

| | | | | | |
|-------------------------------------|---|--|---|---------------------------------|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
EDNA L. MORGAN FURR | | 2. Date of Death
Month MAY Day 26 Year 1996 | | 3. Time of Death
11:38 pm |
| | 4a. Facility Name (If not Institution, give street and number)
1001 N. WOODINGTON RD | | 4b. City, Town, or Location of Death
BALTO | | 4c. County of Death
N/A |
| Funeral
Director | 5. Social Security Number
217-24-4665 | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)
64 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. |
| | 8. Date of Birth (Month, Day, Year)
3/18/32 | | 9. Birthplace (State or Foreign Country)
FLORIDA | | |
| To Be Completed by Funeral Director | Usual Residence of Decedent | | | | |
| | 10a. State
MD | 10b. County
NA | 10c. City, Town or Location
BALTIMORE | | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |
| | 10e. Street and Number
1001 N. WOODINGTON RD. | | 10f. Zip Code
21229 | | 10g. Citizen of What Country?
USA |
| | 11. Marital Status
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |
| | 14. Race - American Indian, Black, White, etc.
Specify: BLACK | | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 8th College (1-4or 5+) SUPERVISOR HOUSEKEEPING | | |
| | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
STELLA MARIS | | 16b. Kind of Business/Industry
STELLA MARIS | | |
| | 17. Father's Name (First, Middle, Last)
CLARENCE BAILEY | | 18. Mother's Name (First, Middle, Maiden Surname)
GENEVA RAMSEY | | |
| | 19a. Informant's Name/Relationship (Type, Print)
DONALD FURR / HUSBAND | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1001 N. WOODINGTON ROAD BALTO., MD 21229 | | |
| | 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
DULANEY VALLEY MEM. | | 20c. Location - City or Town, State
TOWSON, MD |
| | 21. Signature of Funeral Service Licensee
<i>Sharon Stokes</i> | | 22. Name and Address of Facility
MARCH F/H-WEST 4300 WABASH AVE | | |
| Physician
/Medical
Examiner | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
Cardiac Arrhythmia
Due to (or as a consequence of):
Coronary Artery Disease
Due to (or as a consequence of):
Diabetes Mellitus
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last | | | | Approximate Interval Between Onset and Death
Minutes
Years
Years |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |
| | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| | 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | |
| | 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury
M | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| | 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28d. Describe how injury occurred | | |
| | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | 28g. Location (Street and Number or Rural Route Number, City or Town, State) | | |
| | 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | |
| | 29b. Signature and title of certifier
<i>David H Madoff MD, PhD</i> | | 29c. License number
D 31419 | | 29d. Date signed (Month, Day, Year)
5/28/96 |
| | 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)
David H Madoff, MD, PhD. 5601 Loch Raven Blvd, Balt. Md 21239 | | | | |
| State Registrar | 31. Date filed (Month, Day, Year)
MAY 29 1996 | | 32. Registrar's Signature
<i>John Davidson-Randall</i> | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

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State of Maryland / Department of Health and Mental Hygiene

96 15837

Certificate of Death

Reg. No.

| | | | | | | | | | |
|--|--|---|--|--|--|--|--|---|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
<i>Dorothy E. Frantz</i> | | | | 2. Date of Death
Month Day Year
<i>May 27 1996</i> | | 3. Time of Death
<i>0530</i> | | |
| | 4a. Facility Name (If not institution, give street and number)
<i>St Agnes Hospital</i> | | | | 4b. City, Town, or Location of Death
<i>Baltimore</i> | | 4c. County of Death
<i>Baltimore</i> | | |
| Funeral
Director | 5. Social Security Number
<i>217-18-6781</i> | | 6. Sex
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday)
<i>86</i> Yrs. | | 8. Date of Birth (Month, Day, Year)
<i>FEB 15, 1910</i> | | |
| | 9. Birthplace (State or Foreign Country)
<i>MARYLAND</i> | | 10a. State
<i>MD</i> | | 10b. County
<i>BALTIMORE</i> | | 10c. City, Town or Location
<i>BALTIMORE</i> | | |
| Usual Residence of Decedent | | 10d. Inside City Limits
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 10e. Street and Number
<i>4130 WILKENS AVENUE</i> | | 10f. Zip Code
<i>21229</i> | | 10g. Citizen of What Country?
<i>U.S.A.</i> | |
| 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: <i>WHITE</i> | | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) <i>12TH GRADE</i>
College (1-4or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
<i>ACCOUNTANT</i> | | 16b. Kind of Business/Industry
<i>CO. ROWLEY TRANSPORTATION</i> | | | | | |
| 17. Father's Name (First, Middle, Last)
<i>MORRIS H. WALMER</i> | | | | 18. Mother's Name (First, Middle, Maiden Surname)
<i>GERTRUDE L. HANFT</i> | | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
<i>THOMAS FRANTZ (SON)</i> | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
<i>4767 ILKLEY MOOR LANE - ELLICOTT CITY, MD 21043</i> | | | | | |
| 20a. Method of Disposition
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
<i>LOUDON PARK CEMETERY</i> | | 20c. Date
<i>6/1/96</i> | | 20d. Location - City or Town, State
<i>BALTIMORE</i> | | | |
| 21. Signature of Funeral Service Licensee
<i>[Signature]</i> | | | | 22. Name and Address of Facility
<i>HUBBARD FUNERAL HOME, INC.
4107 WILKENS AVENUE-BALTIMORE, MD 21229</i> | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
<i>a. Acute Aortic Occlusion</i>
Due to (or as a consequence of):
<i>b. Myocardial infarction</i>
Due to (or as a consequence of):
<i>c. Hypertension</i>
Due to (or as a consequence of):
<i>d.</i> | | Approximate Interval Between Onset and Death
<i>24 hrs</i>
<i>36 hrs</i> | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown | | | | | |
| | | | | 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA | | 26. Place of Death (Check only one)
Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide
5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
<i>M</i> | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | |
| | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| 29a. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier
<i>[Signature] md Resident</i> | | 29c. License number
<i>205-5</i> | | 29d. Date signed (Month, Day, Year)
<i>May 27 1996</i> | | | |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)
<i>A. Cervoone md</i> | | 31. Date filed (Month, Day, Year)
<i>MAY 29 1996</i> | | 32. Registrar's Signature
<i>[Signature]</i> | | 33. Address of person who completed cause of death (Item 23e)
<i>St. Agnes Hospital 900 Caton Ave Baltimore, MD 21229</i> | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 15838

ITEM#22 film g735 5/30/96ag perFH Certificate of Death

Reg. No.

| | | | | | | | | |
|---|---|--|--|---|--|---|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
LORNE FRANKTON | | | | 2. Date of Death
Month Day Year
MAY 26 1996 | | 3. Time of Death
5:19 A | |
| | 4a. Facility Name (If not institution, give street and number)
ST, AGNES HOSPITAL | | | | 4b. City, Town, or Location of Death
BALTIMORE | | 4c. County of Death
N/A | |
| Funeral
Director | 5. Social Security Number
217-12-7290 | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)
71 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth
(Month, Day, Year)
6-18-24 | 9. Birthplace (State or Foreign Country)
Md. | |
| | Usual Residence of Decedent | | | | | | | |
| To Be Completed by Funeral Director | 10a. State
Md. | 10b. County
N/A | 10c. City, Town or Location
Baltimore | | | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | |
| | 10e. Street and Number
4415 Alan Drive | | | 10f. Zip Code
21229 | | 10g. Citizen of What Country?
U.S.A. | | |
| | 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No
If Yes, Give Year or Dates: II | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: White | |
| | 15. Decedent's Education
(Specify only highest grade completed)
Elementary/Secondary (0-12) Grade 8
College (1-4or 5+) College (1-4or 5+) | | | 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)
Self-employed sheet metal worker | | 16b. Kind of Business/Industry
Business Sheet Metal | | |
| | 17. Father's Name (First, Middle, Last)
John E. Frankton | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Myrtle May Russel | | | |
| | 19a. Informant's Name/Relationship (Type, Print)
Marie J. Frankton | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
4415 Alan Drive-Balto., Md. 21229 | | | |
| | 20a. Method of Disposition
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Good Shepherd Cem. 5-29-96 | | 20c. Location - City or Town, State
Balto., Md. | | | |
| | 21. Signature of Funeral Service Licensee
G. Truman Schwab | | | | 22. Name and Address of Facility
5151 Baltimore National Pike
Baltimore, Md. 21229 BALTIMORE, MD 21229 | | | |
| | 23e. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
Immediate Cause (Final disease or condition resulting in death)
a. <u>Arteriosclerotic Cardiovascular Disease</u>
Due to (or as a consequence of):
b. _____ Due to (or as a consequence of):
c. _____ Due to (or as a consequence of):
d. _____
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown | |
| | | | | | | 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | |
| | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | |
| 25. Was case referred to medical examiner?
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | 26. Place of Death (Check only one)
Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input checked="" type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify) | | | | |
| 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide
5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of injury
M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | |
| 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28d. Describe how injury occurred | | | | |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | |
| 29a. Certifier (Check only one)
1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | |
| 29b. Signature and title of certifier
[Signature] | | | | 29c. License number
O.C.M.E | | 29d. Date signed (Month, Day, Year)
MAY 26.1996 | | |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)
J. ARON LOCKE, MD 111 Penn Street, Baltimore, Maryland 21201 | | | | | | | | |
| 31. Date filed (Month, Day, Year)
MAY 29 1996 | | | | 32. Registrar's Signature
[Signature] | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 96 15839

Certificate of Death

Reg. No.

| | | | | | | | | | | | | | | | | | | | | |
|---|--|---|--|---|---|---|--|--|--|--|---|----|------------------------------|--|---|----|-----------------------|----|--|----|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
ELLENE MARIE GLAZE | | | | | | 2. Date of Death
Month MAY Day 26 Year 1996 | | 3. Time of Death
1300 | | | | | | | | | | | |
| | 4a. Facility Name (If not institution, give street and number)
ST. AGNES HOSPITAL | | | | | | 4b. City, Town, or Location of Death
BALTIMORE | | 4c. County of Death
BALTIMORE CITY | | | | | | | | | | | |
| Funeral
Director | 5. Social Security Number
219-30-5551 | | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday)
61 Yrs. | | 8. Date of Birth (Month, Day, Year)
NOV 8, 1934 | | 9. Birthplace (State or Foreign Country)
MARYLAND | | | | | | | | | | | |
| | Usual Residence of Decedent | | | | | | | | | | | | | | | | | | | |
| To Be Completed by Funeral Director | 10a. State
MARYLAND | | 10b. County
BALTIMORE | | 10c. City, Town or Location
LANSDOWNE | | | | 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | | | | |
| | 10e. Street and Number
132 A HAZEL AVENUE | | | | 10f. Zip Code
21227 | | 10g. Citizen of What Country?
U.S.A. | | | | | | | | | | | | | |
| | 11. Marital Status
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc.
Specify: WHITE | | | | | | | | | | | | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12TH GRADE Collage (1-4or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
HOMEMAKER | | | 16b. Kind of Business/Industry
HOMEMAKING | | | | | | | | | | | | |
| | 17. Father's Name (First, Middle, Last)
HENRY C. SPARROW | | | | | | 18. Mother's Name (First, Middle, Maiden Surname)
IRMA MAE VOLKERT | | | | | | | | | | | | | |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print)
LELAND R. GLAZE, SR. (HUSBAND) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
132 A HAZEL AVENUE - LANSDOWNE, MD. 21227 | | | | | | | | | | | | | | | |
| | 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
LOUDON PARK CEMETERY | | Data
5/30/96 | | 20c. Location - City or Town, State
BALTIMORE | | | | | | | | | | | |
| | 21. Signature of Funeral Service Licensee
 | | | | 22. Name and Address of Facility
HUBBARD FUNERAL HOME, INC.
4107 WILKENS AVENUE-BALTIMORE, MD 21229 | | | | | | | | | | | | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | | | | | | | | | | | | | |
| | <table border="0"> <tr> <td rowspan="4"> Immediate Cause (Final disease or condition resulting in death)

 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last </td> <td>a.</td> <td>ACUTE PULMONARY EDEMA</td> <td rowspan="4"> Due to (or as a consequence of):

 Due to (or as a consequence of):

 Due to (or as a consequence of):

 Due to (or as a consequence of): </td> <td rowspan="4"> Approximate Interval Between Onset and Death

 1 HOUR.

 YEARS. </td> </tr> <tr> <td>b.</td> <td>CARDIOMYOPATHY</td> </tr> <tr> <td>c.</td> <td></td> </tr> <tr> <td>d.</td> <td></td> </tr> </table> | | | | | | | | | | Immediate Cause (Final disease or condition resulting in death)

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | a. | ACUTE PULMONARY EDEMA | Due to (or as a consequence of):

Due to (or as a consequence of):

Due to (or as a consequence of):

Due to (or as a consequence of): | Approximate Interval Between Onset and Death

1 HOUR.

YEARS. | b. | CARDIOMYOPATHY | c. | | d. |
| Immediate Cause (Final disease or condition resulting in death)

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | a. | ACUTE PULMONARY EDEMA | Due to (or as a consequence of):

Due to (or as a consequence of):

Due to (or as a consequence of):

Due to (or as a consequence of): | Approximate Interval Between Onset and Death

1 HOUR.

YEARS. | | | | | | | | | | | | | | | | |
| | b. | CARDIOMYOPATHY | | | | | | | | | | | | | | | | | | |
| | c. | | | | | | | | | | | | | | | | | | | |
| | d. | | | | | | | | | | | | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | | | | | | | | |
| | | | | | | | | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | | | | | |
| | | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | | | | | | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | | | | | | | | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | | | | | | | | | | | | |
| | | 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | | | | | | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier
 | | | | 29c. License number
P. 08217. | | 29d. Date signed (Month, Day, Year)
MAY 26, 1996 | | | | | | | | | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
VIPUT MANTADILOK ST. AGNES HOSPITAL - 900 CATON AVENUE-BALTO., MD 21229 | | | | | | | | | | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
MAY 29 1996 | | 32. Registrar's Signature
 | | | | | | | | | | | | | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 37 is marked other than "natural", or items 23a or 24a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 15840

Certificate of Death

Reg. No.

| | | | | | | | | |
|---|---|---|---|--|---|---|---|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
FERNANDO CLIXTEO GUARTE JR | | | | 2. Date of Death
Month Day Year
MAY 24 1996 | | 3. Time of Death
11:48 PM | |
| | 4a. Facility Name (If not institution, give street and number)
1600 BLOCK EAST CHASE STREET | | | | 4b. City, Town, or Location of Death
BALTIMORE | | 4c. County of Death
N/A | |
| Funeral
Director | 5. Social Security Number
216-94-0740 | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)
17 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth (Month, Day, Year)
NOV 5 1978 | 9. Birthplace (State or Foreign Country)
MD |
| | Usual Residence of Decedent | | | | | | | |
| To Be Completed by Funeral Director | 10a. State
MD | | 10b. County
N/A | | 10c. City, Town or Location
BALTIOMRE | | | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |
| | 10a. Street and Number
1600 NORMAL AVE | | | | 10f. Zip Code
21213 | | 10g. Citizen of What Country?
U.S.A. | |
| | 11. Marital Status
<input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: BLACK | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 10th College (1-4 or 5+) N/A | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
STUDENT | | 16b. Kind of Business/Industry
N/A | |
| | 17. Father's Name (First, Middle, Last)
FERNANDO C GUARTE SR | | | | 18. Mother's Name (First, Middle, Maiden Surname)
WILMA BROWN | | | |
| | 19a. Informant's Name/Relationship (Type, Print)
WILMA BROWN | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1600 NORMAL AVE BALTO, MD 21218 | | | |
| | 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Cedar Hill Cem | | Date
May 24 | | 20c. Location - City or Town, State
Balto, MD | |
| | 21. Signature of Funeral Service Licensee
<i>Patricia Betts</i> | | | | 22. Name and Address of Facility
BETTS FUNERAL HOME
1129 N. CAROLINE ST BALTO, MD 21213 | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
Multiple Gunshot Wounds | | | | | | | |
| | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | | | |
| 24a. Was an autopsy performed?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | |
| 25. Was case referred to medical examiner?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | | |
| 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) SCENE | | | | | | | | |
| 27. Manner of Death
<input type="checkbox"/> Natural <input type="checkbox"/> Accidental <input type="checkbox"/> Suicidal <input checked="" type="checkbox"/> Homicidal <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year)
5-24-96 | | 28b. Time of Injury
2335 M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred
Subject shot |
| 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
street | | 28f. Location (Street and Number or Rural Route Number, City or Town, State)
1117 N. Bond St. | | | | | | |
| 29a. Certifier
(Check only one)
<input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.
<input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | |
| 29b. Signature and title of certifier
<i>Clara Locke M.D.</i> | | | | 29c. License number
O.C.M.E. | | 29d. Date signed (Month, Day, Year)
MAY 25, 1996 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
JARON LOCKE, MD 111 Penn Street, Baltimore, Maryland 21201 | | | | | | | | |
| 31. Date filed (Month, Day, Year)
MAY 29 1996 | | | | 32. Registrar's Signature
<i>William Handelle</i> | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 15841

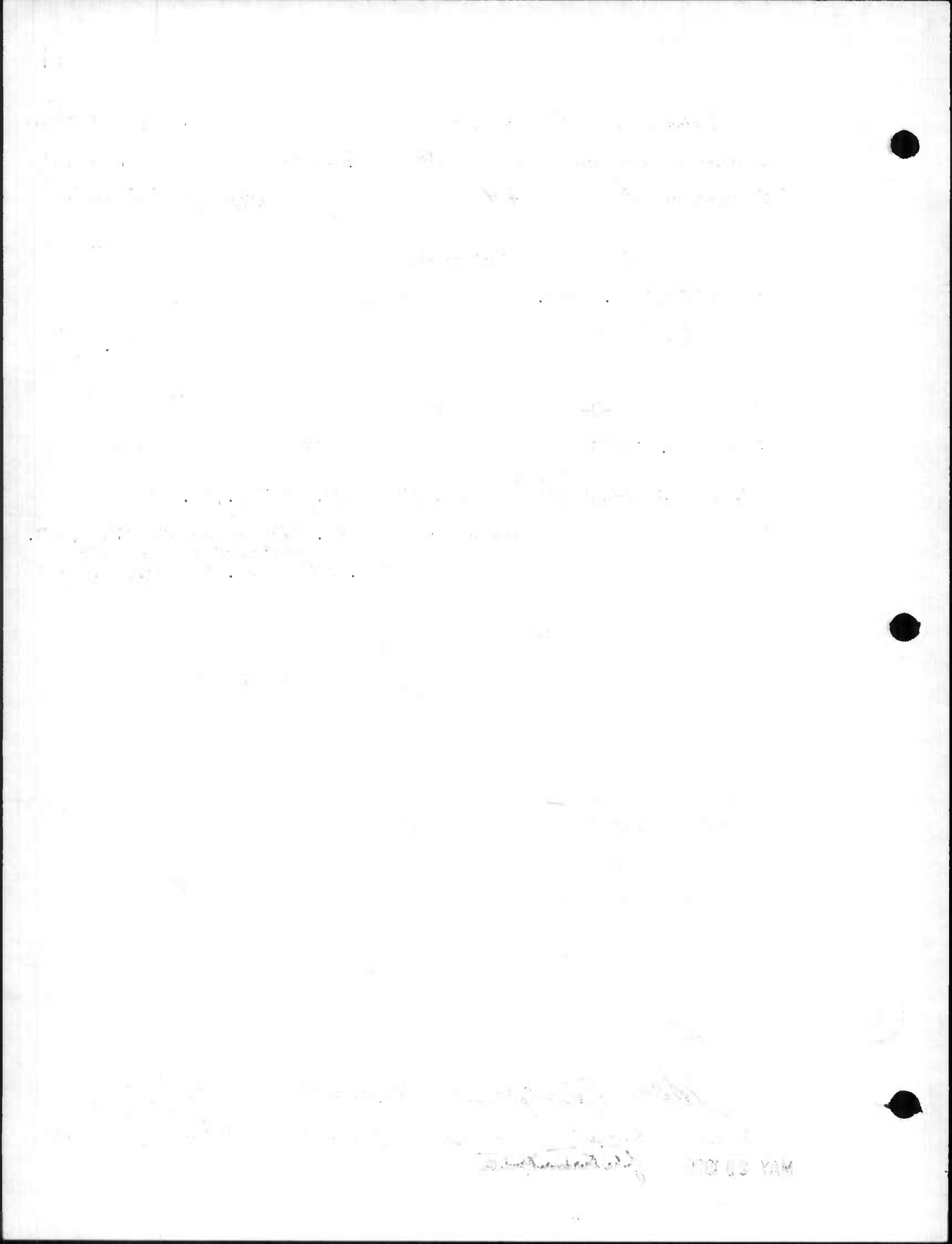
Certificate of Death

Reg. No.

| | | | | | | | | |
|--|--|--|---|--|--|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
James L. Hawkins | | | | 2. Date of Death
Month 05 Day 24 Year 96 | | 3. Time of Death
11:30 am | |
| | 4a. Facility Name (If not institution, give street and number)
Baltimore VA Medical Center | | | | 4b. City, Town, or Location of Death
Baltimore | | 4c. County of Death
Baltimore City | |
| Funeral
Director | 5. Social Security Number
217-18-5410 | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday)
74 Yrs. | | 8. Date of Birth (Month, Day, Year)
08/06/21 | |
| | 9. Birthplace (State or Foreign)
MARYLAND | | 10e. State
MD | | 10b. County
N/A | | 10c. City, Town or Location
BALTIMORE | |
| Usual Residence of Decedent | | | | | | | | |
| 10e. State
MD | | | 10b. County
N/A | | | 10c. City, Town or Location
BALTIMORE | | |
| 10e. Street and Number
301 McMECHEN ST. APT. 309 | | | 10f. Zip Code
21217 | | | 10g. Citizen of What Country?
US | | |
| 11. Marital Status
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | | 12. Was Decedent Ever In U.S. Armed Forces?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
If Yes, Give Year or Dates: | | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | |
| 14. Race - American Indian, Black, White, etc.
Specify: BLK. | | | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 8 College (1-4or 5+) -0- | | | 16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
CLERK | | |
| 16. Kind of Business/Industry
FOOD | | | 17. Father's Name (First, Middle, Last)
JOHN W. OWENS | | | 18. Mother's Name (First, Middle, Maiden Surname)
ROSIE HAWKINS | | |
| 19e. Informant's Name/Relationship (Type, Print) (wife)
ELIZABETH OWENS-HAWKINS | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
301 McMECHEN ST. BALTIMORE, MD. 21217 | | | | | |
| 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
GARRISON FOREST VET. 5/30/96 OWINGS MILLS, MD. | | | | | |
| 21. Signature of Funeral Service Licensee
<i>[Signature]</i> CFSP#281 | | | 22. Name and Address of Facility
PHILLIPS FUNERAL HOME
1721-27 N. MONROE ST. BALTIMORE, MD. 21217 | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | | |
| Immediate Cause (Final disease or condition resulting in death)
Hypoxia / EMD
Due to (or as a consequence of):
possible pulmonary embolus
Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
Due to (or as a consequence of): | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
status post sigmoid colectomy for colon cancer | | | | | | | | |
| 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | | | | | | | |
| 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | |
| 26. Place of Death (Check only one)
Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation
<input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined
<input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | | 28a. Date of Injury (Month, Day, Year) | | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input type="checkbox"/> No |
| 28d. Describe how injury occurred | | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | |
| 29b. Signature and title of certifier
<i>[Signature]</i> | | | 29c. License number
P09788 | | | 29d. Date signed (Month, Day, Year)
05/24/96 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Adam C. Berger 22 South Greene St. Baltimore, MD 21201 | | | | | | | | |
| 31. Date filed (Month, Day, Year)
MAY 29 1996 | | | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



96 15842

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|--|---|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last)
WILLIE HARRISON | | | | 2. DATE OF DEATH
MONTH 5 DAY 23 YEAR 96 | | 3. TIME OF DEATH
8:15AM | |
| 4. SOCIAL SECURITY NUMBER
246-18-1771 | | 5. SEX
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
77 YRS. | | 7. DATE OF BIRTH (Month, Day, Year)
JAN 23, 1919 | |
| 9a. FACILITY NAME (If not institution, give street and number)
RIXTON NURSING HOME | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
BALTO | | 9c. COUNTY OF DEATH
N/A | |
| 10a. STATE
MD | | 10b. COUNTY
N/A | | 10c. CITY, TOWN OR LOCATION
BALTO. | | 10d. INSIDE CITY LIMITS?
<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER
1604 BOND ST | | | | 10f. ZIP CODE
21213 | | 10g. CITIZEN OF WHAT COUNTRY?
USA | |
| 11. MARITAL STATUS
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify: BLACK | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12) 10th
College (1-4 or 5+) N/A | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
STEEL WORKER | | 16b. KIND OF BUSINESS/INDUSTRY
STEEL CO | | | |
| 17. FATHER'S NAME (First, Middle, Last)
BOWLEY HARRIS | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
MARY LEWIS | | | |
| 19a. INFORMANT'S NAME (Type/Print)
HATTIE HARRISON | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1604 N. BOND ST BALTO, MD 21213 | | | |
| 20a. METHOD OF DISPOSITION
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
BALTIMORE CEM | | DATE MAY 29, 96 | | 20c. LOCATION — City or Town, State
BALTO, MD | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
 | | | | 22. NAME AND ADDRESS OF FACILITY
BETTS FUNERL HOME
1129 N. CAROLINE ST BALTO, MD 21213 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. CARCINOMA of COLON
DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. DUE TO (OR AS A CONSEQUENCE OF):
c. DUE TO (OR AS A CONSEQUENCE OF):
d. | | | | | | | Approximate interval Between Onset and Death
1 yr. |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/> | | | | | | | 24a. WAS AN AUTOPSY PERFORMED?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
<input type="checkbox"/> YES <input type="checkbox"/> NO | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DDA
OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH
1 <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
5 <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M | | 28c. INJURY AT WORK?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. CERTIFIER (Check only one)
<input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
 | | | | 29c. LICENSE NUMBER
D-12849 | | 29d. DATE SIGNED (Month, Day, Year)
5-23-96 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
A.H. GHILADI, M.D. 7600 OSLER Dr. Towson Md. 21204 | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
MAY 29 1996 | | | | 32. REGISTRATION NUMBER | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 15843

Certificate of Death

Reg. No.

| | | | | | | | | |
|---|--|---|--|---|--|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
NANNIE S. HUPP | | | | 2. Date of Death
Month 05 - Day 25 - Year 1996 | | 3. Time of Death
6:13 am | |
| | 4a. Facility Name (If not institution, give street and number)
CROMWELL CENTER GENESIS ELDERCARE | | | | 4b. City, Town, or Location of Death
PARKVILLE | | 4c. County of Death
BALTIMORE | |
| Funeral
Director | 5. Social Security Number
229-16-7180 | | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)
95 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth
(Month, Day, Year)
7-8-1900 | 9. Birthplace (State or Foreign Country)
VIRGINIA |
| | Usual Residence of Decedent | | | | | | | |
| 10a. State
MD. | | 10b. County
BALTIMORE | | 10c. City, Town or Location
PARKVILLE | | | 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 10e. Street and Number
8710 EMGE RD. | | | | 10f. Zip Code
21234 | | 10g. Citizen of What Country?
U.S.A. | | |
| 11. Marital Status
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc.
Specify: WHITE | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 6YRS. College (1-4or 5+) | | | | 18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
HOUSEWIFE | | | 16b. Kind of Business/Industry
HOMEMAKER | |
| 17. Father's Name (First, Middle, Last)
SAMUEL JORDON | | | | 18. Mother's Name (First, Middle, Maiden Surname)
ELIZABETH HODNETT | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
ALLEN OSBORNE | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
8800 WALTHER BLVD. BALTO., MD. 21234. | | | | |
| 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
UNION METH. CEMETERY | | Date
5/28/96 | | 20c. Location - City or Town, State
HALIFAX CO., VA. |
| 21. Signature of Funeral Service Licensee
 | | | | 22. Name and Address of Facility
HENRY W. JENKINS & SONS CO.
4905 YORK RD. BALTO., MD. 21212. | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
e. Arteriosclerotic coronary artery disease
Due to (or as a consequence of):

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. | | | | | | | | Approximate interval Between Onset and Death |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Asperillar pneumonia | | | | | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |
| 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input type="checkbox"/> No | | 28d. Describe how injury occurred |
| 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | |
| 29b. Signature and title of certifier
 | | | | 29c. License number
D21022 | | 29d. Date signed (Month, Day, Year)
5-28-96 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
MARION KOWALEWSKI M.D. 8604 HARFORD RD. BALTO., MD. | | | | | | | | |
| 31. Date filed (Month, Day, Year)
MAY 29 1996 | | | | 32. Registrar's Signature
 | | | | |

Baltimore, Maryland 21215-0020

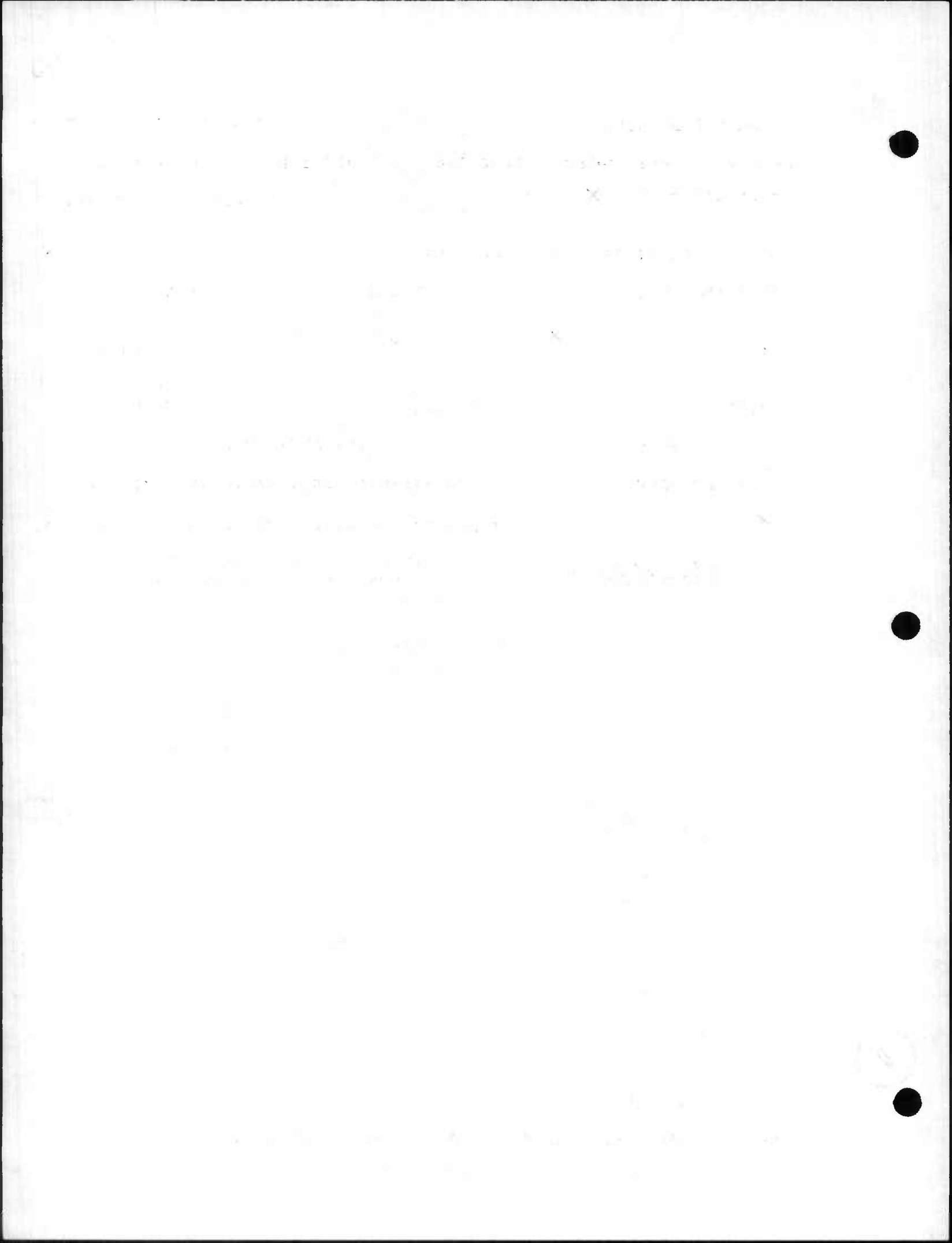
Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 505a.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

96 15845

Reg. No.

Physician
/Medical
Examiner

Funeral
Director

| | | | | | | | |
|---|--|---|--|--|--|---|--|
| 1. Decedent's Name (First, Middle, Last)
Gertrude E. Irwin | | | | 2. Date of Death
Month Day Year
May 19 1996 | | 3. Time of Death
3:05 PM | |
| 4a. Facility Name (If not institution, give street and number)
Meridian Nursing Home - Hammonds Lane | | | | 4b. City, Town, or Location of Death
Baltimore | | 4c. County of Death
Anne Arundel | |
| 5. Social Security Number
212 48 2525 | | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday)
90 Yrs. | | 8. Date of Birth (Month, Day, Year)
May 19, 1906 | |
| 9. Birthplace (State or Foreign Country)
Maryland | | 10a. State
Maryland | | 10b. County
Anne Arundel | | 10c. City, Town or Location
Baltimore | |
| 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 10e. Street and Number
Meridian Nursing Home
613 Hammonds Lane | | 10f. Zip Code
21225 | | 10g. Citizen of What Country?
U.S. | |
| 11. Marital Status
<input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: White | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 8th
College (1-4 or 5+) College | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Home Maker | | 16b. Kind of Business/Industry
Own Home | | | |
| 17. Father's Name (First, Middle, Last)
Thomas Joseph Irwin | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Frances Shelhaus | | | |
| 19a. Informant's Name/Relationship (Type, Print)
Edward J. Auer | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
409 Sanders Street Baltimore, Maryland 21230 | | | |
| 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
New Cathedral Cemetery | | Date
5/23/96 | | 20c. Location - City or Town, State
Baltimore, Maryland | |
| 21. Signature of Funeral Service Licensee
<i>Donna M. Zmijewski</i> | | | | 22. Name and Address of Facility
Gonce Funeral Home P.A.
4001 Ritchie Highway Baltimore, Md. 21225 | | | |
| 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. Pneumonia
Due to (or as a consequence of):
b. Dementia
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last | | | | | | | Approximate Interval Between Onset and Death
5 days
5 yrs |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Chronic Atrial Fibrillation
Hypertensive Atherosclerotic Cardiovascular Disease | | | | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |
| 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. Signature and title of certifier
<i>Alan N. Dennis MD</i> | | | | 29c. License number
D30555 | | 29d. Date signed (Month, Day, Year)
5/22/96 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Alan N. Dennis 707 E Fort Ave Baltimore MD 21230 | | | | | | | |
| 31. Date filed (Month, Day, Year)
MAY 29 1996 | | 32. Registrar's Signature
<i>Julia T. Anderson-Randall</i> | | | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State
Registrar

96 15846

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|--|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
Anna Johnson | | | | 2. DATE OF DEATH
MONTH 5 DAY 27 YEAR 96 | | 3. TIME OF DEATH
1:00 P.M. | |
| 4. SOCIAL SECURITY NUMBER
142-20-4750 | | 5. SEX
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
86 YRS. | | 7. DATE OF BIRTH (Month, Day, Year)
4-15-10 | |
| 8. FACILITY NAME (If not institution, give street and number)
Bayview Hospital | | | | 9a. CITY, TOWN OR LOCATION OF DEATH
Baltimore | | 9c. COUNTY OF DEATH
NA | |
| 10a. STATE
MD | | | | 10b. COUNTY
NA | | 10c. CITY, TOWN OR LOCATION
BALTIMORE | |
| 10e. STREET AND NUMBER
1015 N. DENTACLOU ST. | | | | 10f. ZIP CODE
21216 | | 10g. CITIZEN OF WHAT COUNTRY?
USA | |
| 11. MARITAL STATUS
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify: Black | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12) 12th College (1-4 or 5+) NA | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
Domestic Worker | | 16b. KIND OF BUSINESS/INDUSTRY
Household | |
| 17. FATHER'S NAME (First, Middle, Last)
James E. Overton | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Mattie S. Overton | | | |
| 19a. INFORMANT'S NAME (Type/Print)
Nicole Overton | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1015 N. DENTACLOU ST. Balto md 21216 | | | |
| 20a. METHOD OF DISPOSITION
<input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
Metrol crematory | | 20c. DATE
5/30/96 | | 20d. LOCATION — City or Town, State
Balto, md | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
Stephen B. Harris | | | | 22. NAME AND ADDRESS OF FACILITY
MARSH FUNERAL Home, West 4300 Wabash Ave. Balto. md 21215 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Aspiration Pneumonitis
DUE TO (OR AS A CONSEQUENCE OF):
b. Parkinsonism
DUE TO (OR AS A CONSEQUENCE OF):
c. Dementia of the Alzheimers Type
DUE TO (OR AS A CONSEQUENCE OF):
d.
Approximate Interval Between Onset and Death
Immediate
months
years | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA
OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M | | 28c. INJURY AT WORK?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | | | 28e. PLACE OF INJURY — At home, term, street, factory, office building, etc. (Specify) | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | 29a. CERTIFIER (Check only one)
<input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
Cynthia Kuttner, MD | | | | 29c. LICENSE NUMBER
D47451 | | 29d. DATE SIGNED (Month, Day, Year)
5/28/96 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type: Print)
Cynthia Kuttner, MD Johns Hopkins Geriatric Center 5505 Hopkins Bayview Circle, Baltimore, Maryland | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
MAY 29 1996 | | | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 15847

Certificate of Death

Reg. No.

| | | | | | | | | | |
|--|--|---------------------------|---|---|--|--|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Barbara Jean Higginbotham Jackson | | | | 2. Date of Death
Month May Day 20 Year 1996 | | 3. Time of Death
8:10 PM | | |
| | 4a. Facility Name (If not institution, give street and number)
4007 - 6th Street | | | | 4b. City, Town, or Location of Death
Baltimore | | 4c. County of Death
N/A | | |
| Funeral
Director | 5. Social Security Number
218 28 0722 | | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)
62 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth (Month, Day, Year)
Oct. 13, 1933 | 9. Birthplace (State or Foreign Country)
West Virginia | |
| | Usual Residence of Decedent | | | | | | | | |
| 10a. State
Maryland | | 10b. County
N/A | | 10c. City, Town or Location
Baltimore | | | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | |
| 10e. Street and Number
4105 Rondo Court | | | | 10f. Zip Code
21225 | | 10g. Citizen of What Country?
U.S. | | | |
| 11. Marital Status
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced | | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: White | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 8th College (1-4or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Home Maker | | | 16b. Kind of Business/Industry
In own home | | |
| 17. Father's Name (First, Middle, Last)
Jessie Higginbotham | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Loreda Woodrum | | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
David Garrett | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
604 Luzerne Avenue Baltimore, Maryland 21224 | | | | | |
| 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Glen Haven Memorial Park | | 20c. Location - City or Town, State
5/24/96 Glen Burnie, Maryland | | | |
| 21. Signature of Funeral Service Licensee
<i>Jerome Zimninski</i> | | | | 22. Name and Address of Facility
Gonce Funeral Home P.A.
4001 Ritchie Highway Baltimore, Md. 21225 | | | | | |
| 23. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. Metastatic Small Cell Carcinoma Lung
Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown

24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No

24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input type="checkbox"/> No | |
| | | | | 28d. Describe how injury occurred | | 28e. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | 29b. Signature and title of certifier
<i>[Signature]</i> | | 29c. License number
03/551 | | 29d. Date signed (Month, Day, Year)
May 22, 1996 | |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)
Russell O. DeLuca 3001 S. Harpers St, Baltimore MD 21225 | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
MAY 29 1996 | | | | 32. Registrar's Signature
<i>[Signature]</i> | | | | | |

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 15848

Certificate of Death

Reg. No.

| | | | | | | | | |
|--|---|--|---|--|---|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Valerie Johnson | | | | 2. Date of Death
Month May Day 15 Year 1996 | | 3. Time of Death
9:00 PM | |
| | 4a. Facility Name (If not institution, give street and number)
Maryland General Hospital | | | | 4b. City, Town, or Location of Death
Baltimore City | | 4c. County of Death | |
| Funeral
Director | 5. Social Security Number
217-80-0981 | | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday)
36 Yrs. | | 8. Date of Birth (Month, Day, Year)
06 01 59 | |
| | 9. Birthplace (State or Foreign Country)
MARYLAND | | 10a. State
MARYLAND | | 10b. County
N/A | | 10c. City, Town or Location
BALTIMORE | |
| To Be Completed by Funeral Director | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 10e. Street and Number
2212 DRUID HILL AVENUE | | 10f. Zip Code
21217 | | 10g. Citizen of What Country?
USA | |
| | 11. Marital Status
<input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: Black | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (1-4 or 5+) CASHIER | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
DUNKIN DONUTS | | 16b. Kind of Business/Industry | | | |
| | 17. Father's Name (First, Middle, Last)
HERBERT JOHNSON | | | | 18. Mother's Name (First, Middle, Maiden Surname)
ELIZABETH BROWN | | | |
| | 19a. Informant's Name/Relationship (Type, Print)
ELIZABETH BROWN? MOTHER | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
2212 DRUID HILL AVENUE BALTO. MD. 21217 | | | |
| | 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
MOUNT ZION | | 20c. Location - City or Town, State
5/23/96 LANSDOWNE, MD | | | |
| | 21. Signature of Funeral Service Licensee
<i>Joseph R. Walters, Jr.</i> | | | | 22. Name and Address of Facility
UNITY FUNERAL HOME
108 W. NORTH AVENUE BALTO. MD. 21201 | | | |
| | 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

End Stage Cervical Cancer
a. Due to (or as a consequence of):
Ascites
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of): | | | | | | | |
| | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | | | | | | |
| | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | | |
| To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate. | 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | |
| | 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation
<input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined
<input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input type="checkbox"/> No | |
| | 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28d. Describe how injury occurred | | | |
| | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| Medical Certification: To Be Completed by Physician/Medical Examiner | 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | |
| | 29b. Signature and title of certifier
<i>[Signature]</i> | | | | 29c. License number
D31464 | | 29d. Date signed (Month, Day, Year)
May 15, 1996 | |
| | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Shoaib Hashmi, M.D. c/o Maryland General Hospital | | | | | | | |
| | 31. Data filed (Month, Day, Year)
MAY 29 1996 | | | | | | | |

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 15849

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

LILLIAN E. KLOCKE

2. Date of Death

Month
MAY

Day

22,

Year

1996

3. Time of Death

7:45 P.M.

4a. Facility Name (If not institution, give street and number)

CROFTON CONVALESCENT CENTER

4b. City, Town, or Location of Death

CROFTON

4c. County of Death

ANNE ARUNDEL

Funeral
Director

5. Social Security Number

213-32-9948

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

81

If Under 1 Year

Months

If Under 24 Hrs.

Days

8. Date of Birth

(Month, Day, Year)
JAN. 16, 1915

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MD

10b. County

ANNE ARUNDEL

10c. City, Town or Location

PASADENA

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

8339 FAIRWOOD DRIVE

10f. Zip Code

21122

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: WHITE

15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
12TH GRADE

College (14 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

HOMEMAKER

16b. Kind of Business/Industry

HOMEMAKING

17. Father's Name (First, Middle, Last)

JOHN FOX

18. Mother's Name (First, Middle, Maiden Surname)

MAMIE FRAZIER

19a. Informant's Name/Relationship (Type, Print)

EVELYN OWENS (DAUGHTER)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

8339 FAIRWOOD DRIVE - PASADENA, MD 21122

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

CEDAR HILL CEMETERY

Date

5/25/96

20c. Location - City or Town, State

BALTIMORE

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

HUBBARD FUNERAL HOME, INC.

4107 WILKENS AVENUE - BALTIMORE, MD

21229

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)a. Dementia

Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

3 years

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

CardiomyopathyGastro Intestinal Bleed

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical
examiner?
1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

26. Place of Death (Check only one)

4 ☒ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
Investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of

Injury

28c. Injury at

Work?

1 ☐ Yes 2 ☐ No28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

29c. License number

D35848

29d. Date signed (Month, Day, Year)

May 23, 1996

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

DR. HOWARD K. SCHULTZ - 1438 DEFENSE HIGHWAY - SUITE 201 - GAMBRILLS, MD 21054

31. Date filed (Month, Day, Year)

MAY 29 1996

State
Registrar

Baltimore, Maryland 21215-0020

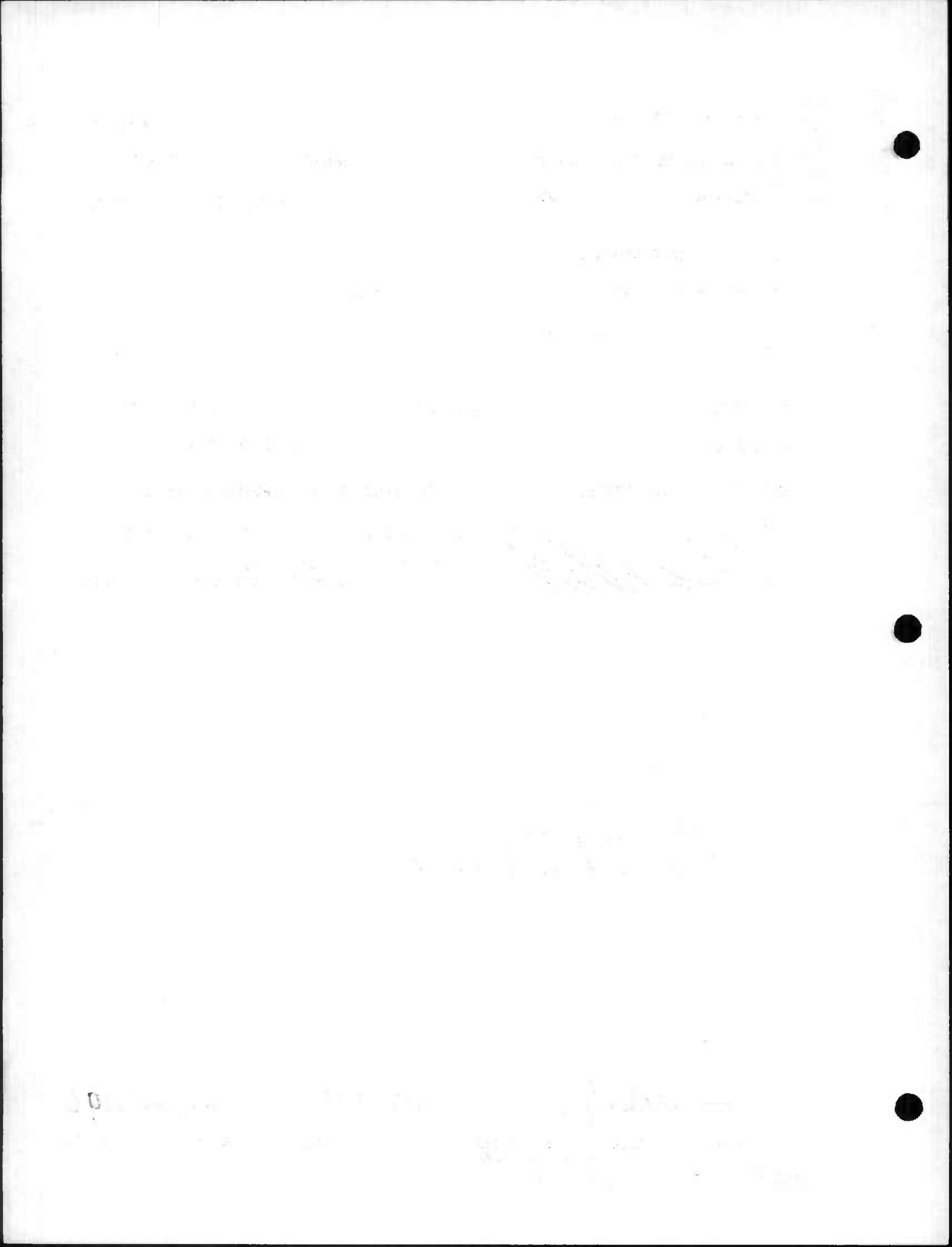
Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit
certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 96 15850
Certificate of Death

Reg. No.

| | | | | | | | | | | | | | |
|--|--|--------------------------|---|---|--|--|--|---|--|--------------------------------|--|---|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Anna C. KAHL | | | | | 2. Date of Death
Month Day Year
May 24, 1996 | | 3. Time of Death
4:45 PM | | | | | |
| | 4a. Facility Name (If not institution, give street and number)
Franklin Square Hospital | | | | | 4b. City, Town, or Location of Death
Baltimore | | 4c. County of Death
Baltimore | | | | | |
| Funeral
Director | 5. Social Security Number
220-03-6752 | | 6. Sex
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)
75 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth (Month, Day, Year)
Jan. 7, 1921 | | 9. Birthplace (State or Foreign Country)
Maryland | | | | |
| | Usual Residence of Decedent | | | | | | | | | | | | |
| 10a. State
Md. | | 10b. County
Baltimore | | 10c. City, Town or Location
Baltimore | | | | 10d. Inside City Limits
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | |
| 10e. Street and Number
4116 Cliffvale Road | | | | 10f. Zip Code
21236 | | | 10g. Citizen of What Country?
U.S.A. | | | | | | |
| 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc.
Specify: White | | | | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 8th
College (1-4or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Home Maker | | | 16b. Kind of Business/Industry
Own Home | | | | | | |
| 17. Father's Name (First, Middle, Last)
Casper Fischer | | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Margaret Lindenberg | | | | | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
Charlene Betz | | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
21430 Lynn Drive Lexington Park, Md. 20653-1143 | | | | | | | | |
| 20a. Method of Disposition
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Bel Air Memorial Gardens | | | Date
May 28 | | 20c. Location - City or Town, State
Bel Air, Md. | | | | | |
| 21. Signature of Funeral Service Licensee
Robert J. Godack, Jr. | | | | | 22. Name and Address of Facility
Schimunek Funeral Home, Inc.
9705 Belair Road Baltimore, Md. 21236 | | | | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
e. Intracranial bleed
Due to (or as a consequence of):

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. | | | | | | | | | Approximate Interval Between Onset and Death
24 hours | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | | | | | |
| | | | | | | 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | |
| 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | 26. Place of Death (Check only one)
Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | | | | |
| 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide
5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | | | | |
| | | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | |
| 29a. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | 29b. Signature and title of certifier
Stuart Willes, M.D. | | | | | | | 29c. License number
D 36663 | | 29d. Date signed (Month, Day, Year)
May 25, 1996 | |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)
Dr. Stuart Willes 9000 Franklin Square Dr. Baltimore, Maryland 21237 | | | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
MAY 29 1996 | | | 32. Registrar's Signature
John Davidson | | | | | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: This certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

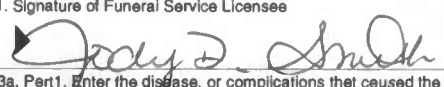
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 15851

Certificate of Death

Reg. No.

| | | | | | | | | |
|---|--|---|--|--|--|--|---|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Bernard V. Kratzmeier | | | | 2. Date of Death
Month Day Year
May 26, 1996 | | 3. Time of Death
7:43AM | |
| | 4a. Facility Name (If not institution, give street and number)
St. Joseph Hospital | | | | 4b. City, Town, or Location of Death
Towson | | 4c. County of Death
Baltimore | |
| Funeral
Director | 5. Social Security Number
215-09-9110 | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)
78 Yrs. | 8. Date of Birth (Month, Day, Year)
April 18, 1918 | 9. Birthplace (State or Foreign Country)
Maryland | | |
| | Usual Residence of Decedent | | | | | | | |
| 10a. State
Md. | | 10b. County
N/A | | 10c. City, Town or Location
Baltimore | | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | |
| 10e. Street and Number
4501 White Ave. | | | | 10f. Zip Code
21206 | | 10g. Citizen of What Country?
U.S.A. | | |
| 11. Marital Status
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
If Yes, Give Year or Dates: WWII | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: White | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 10th College (1-4or 5+) N/A | | | | 18e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Lieutenant | | 16b. Kind of Business/Industry
Balto. City Fire Dept. | | |
| 17. Father's Name (First, Middle, Last)
Albert Kratzmeier | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Clara Schram | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
Ms. Loyce M. Kent | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1208 Apparition Lane Baltimore, Md. 21220 | | | | |
| 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Centre Co. Memorial Park | | Date
5/30 | | 20c. Location - City or Town, State
State College, Pa. | | |
| 21. Signature of Funeral Service Licensee
 | | | | 22. Name and Address of Facility
Hartley Miller Funeral Home
7527 Harford Rd. Baltimore, Md. 21234 | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. Myocardial infarction
Due to (or as a consequence of):
b. Lung Cancer
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
c.
Due to (or as a consequence of):
d. | | | | | | | | |
| Approximate Interval Between Onset and Death
1 hr | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | |
| | | | | | | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| | | 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier
 | | 29c. License number
D32929 | | 29d. Date signed (Month, Day, Year)
5/29/96 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Richard G. D'Antonio MD 7401 Olden Drive #201
Towson MD 21204 | | | | | | | | |
| 31. Date filed (Month, Day, Year)
MAY 29 1996 | | 32. Registrar's Signature
 | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

12 fl

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 15852

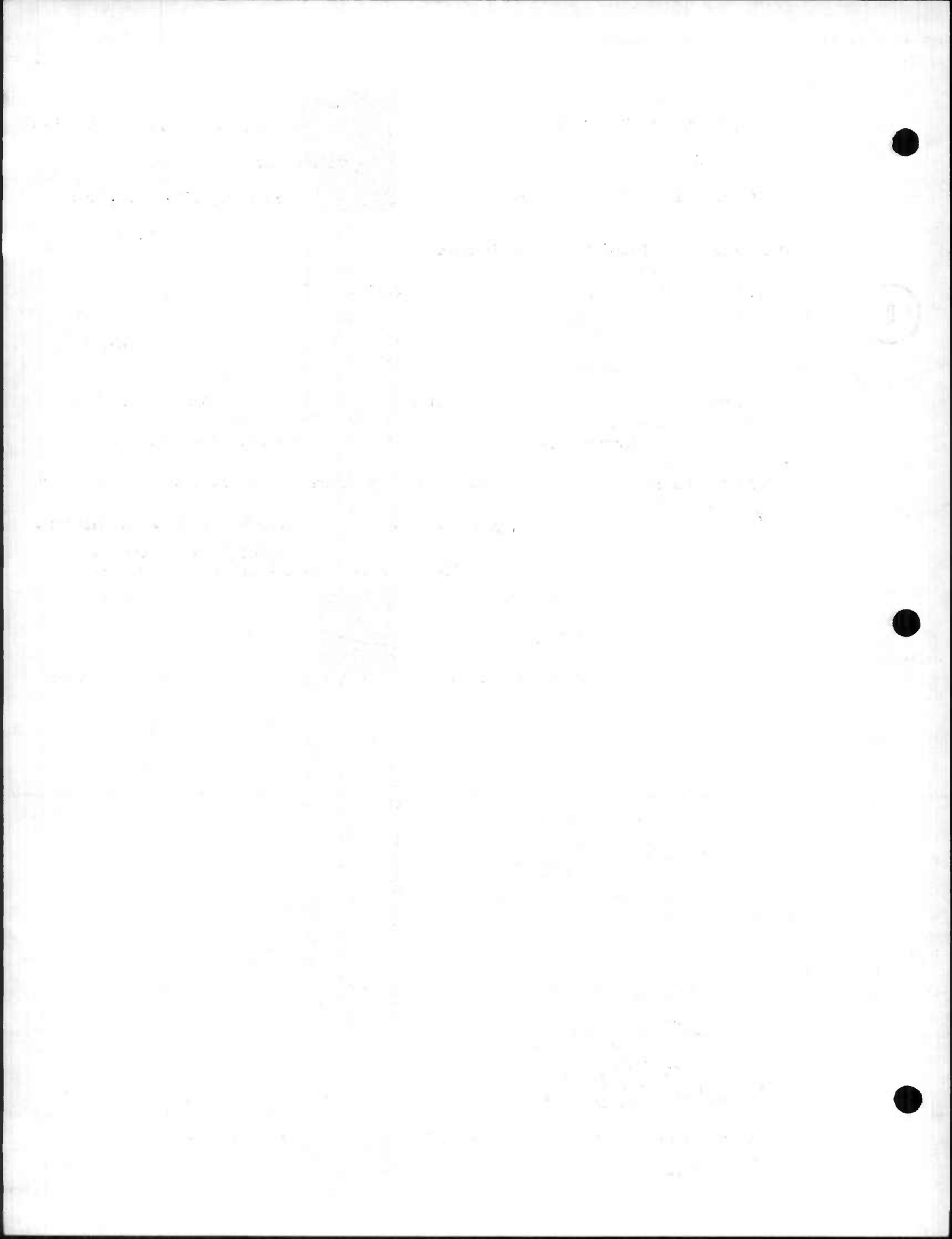
Certificate of Death

Reg. No.

| | | | | | | | | | | | | | | | |
|---|---|--|---|--|--|--|---|---|--|--|---|------------------------------------|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
EDWARD KOSNIK | | | | | | 2. Date of Death
Month Day Year
MAY 28, 1996 | | 3. Time of Death
02:15 | | | | | | |
| | 4a. Facility Name (If not institution, give street and number)
UMMS | | | | | | 4b. City, Town, or Location of Death
BALTIMORE | | 4c. County of Deeth
N/A | | | | | | |
| Funeral
Director | 5. Social Security Number
216 05 6468 | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (in yrs. last birthday)
78 Yrs. | | 8. Date of Birth (Month, Day, Year)
July 25, 1917 | | 9. Birthplace (State or Foreign Country)
Maryland | | | | | | |
| | Usual Residence of Decedent | | | | | | | | | | | | | | |
| To Be Completed by Funeral Director | 10a. State
Maryland | | 10b. County
Anne Arundel | | 10c. City, Town or Location
Baltimore | | | | 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | |
| | 10e. Street and Number
5712 Franklin Street | | | | 10f. Zip Code
21225 | | 10g. Citizen of What Country?
U.S. | | | | | | | | |
| | 11. Marital Status
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc.
Specify: White | | | | | | | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12th College (1-4or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Laborer | | | | 16b. Kind of Business/Industry
Western Electric | | | | | | | | |
| To Be Completed by Physician/Medical Examiner | 17. Father's Name (First, Middle, Last)
Anthony Kosnik | | | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Frances Wiecherezska | | | | | | | | |
| | 19a. Informant's Name/Relationship (Type, Print)
Frances Kosnik | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
5712 Franklin Street Baltimore, Maryland 21225 | | | | | | | | | | |
| | 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Holy Cross Cem. | | Date
5/30/96 | | 20c. Location - City or Town, State
Baltimore, Maryland | | | | | | | | |
| | 21. Signature of Funeral Service Licensee
 | | | | 22. Name and Address of Facility
Gonce Funeral Home P.A.
4001 Ritchie Highway Baltimore, Md. 21225 | | | | | | | | | | |
| Physician
/Medical
Examiner | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. Cerebral Herniation
Due to (or as a consequence of):
b. Intracerebral Hematoma
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d. | | | | | | | | | | Approximate Interval Between Onset and Death
4 DAYS | | | | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | | | | | | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | |
| | 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | | | 26. Place of Death (Check only one)
Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | |
| | 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how Injury occurred | | | | | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | | | 29b. Signature and title of certifier
 | | 29c. License number
7301 | | 29d. Date signed (Month, Day, Year)
MAY 28, 1996 | |
| State Registrar | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
D. HANTER 22 GREEN ST. BALTIMORE, MD 21201 | | | | | | | | | | 31. Date filed (Month, Day, Year)
MAY 29 1996 | | 32. Registrar's Signature
 | | |



96 15853

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
Frances Krushensky | | | | 2. DATE OF DEATH
MONTH May DAY 17 YEAR 1996 | | 3. TIME OF DEATH
2:30 P. M. | |
| 4. SOCIAL SECURITY NUMBER
388 24 5477 | | 5. SEX
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
82 YRS. | | 7. DATE OF BIRTH (Month, Day, Year)
Feb. 27, 1914 | |
| 8. BIRTHPLACE (State or Foreign Country)
North Dakota | | | | 9a. FACILITY NAME (If not institution, give street and number)
Meridian Nursing Home-Loch Raven | | 9b. CITY, TOWN OR LOCATION OF DEATH
Baltimore | |
| 9c. COUNTY OF DEATH
Baltimore | | | | 10a. STATE
Maryland | | | |
| 10b. COUNTY
Baltimore | | | | 10c. CITY, TOWN OR LOCATION
Baltimore | | | |
| 10d. INSIDE CITY LIMITS?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | 10e. STREET AND NUMBER
Meridian Nursing Home
8720 Emge Road | | | |
| 10f. ZIP CODE
21234 | | | | 10g. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | |
| 11. MARITAL STATUS
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify:
White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)
unknown | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
Home Maker | | 16b. KIND OF BUSINESS/INDUSTRY
Own Home | | | |
| 17. FATHER'S NAME (First, Middle, Last)
(Unknown) Walton | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
(unknown) | | | |
| 19a. INFORMANT'S NAME (Type/Print)
Wally Childs | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
500 Virginia Avenue Apt. 911 Towson, Md. 21204 | | | |
| 20a. METHOD OF DISPOSITION
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory, or other place)
Wisconsin Memorial Park | | DATE
5/28/96 | | 20c. LOCATION — City or Town, State
Brookfield, Wisconsin | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
<i>George J. Gonce</i> | | | | 22. NAME AND ADDRESS OF FACILITY
George J. Gonce Funeral Home P.A.
4001 Ritchie Hwy. Baltimore, Md. 21225 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
IMMEDIATE CAUSE (Final disease or condition resulting in death) → Renal failure
DUE TO (OR AS A CONSEQUENCE OF):
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
a. DUE TO (OR AS A CONSEQUENCE OF):
b. DUE TO (OR AS A CONSEQUENCE OF):
c. DUE TO (OR AS A CONSEQUENCE OF):
d. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Congestive heart failure | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
<input type="checkbox"/> YES <input type="checkbox"/> NO | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA
OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation
<input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined
<input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M | | 28c. INJURY AT WORK?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. CERTIFIER (Check only one)
1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
<i>Marion Kowalewski</i> | | | | 29c. LICENSE NUMBER
A 21022 | | 29d. DATE SIGNED (Month, Day, Year)
5-20-96 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
Dr. Marion Kowalewski 8604 Harford Road Baltimore, Maryland 21234 | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
MAY 29 1996 | | | | 32. REGISTRAR'S SIGNATURE
<i>John K. ...</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Dr.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 15854

Certificate of Death

Reg. No.

| | | | | | | | | |
|---|--|--|---|--|--|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Ardaman Kaur | | | | 2. Date of Death
Month Day Year
May 22 1996 | | 3. Time of Death
1:03 PM | |
| | 4a. Facility Name (If not institution, give street and number)
Suburban Hospital | | | | 4b. City, Town, or Location of Death
Bethesda | | 4c. County of Death
Montgomery | |
| Funeral
Director | 5. Social Security Number
212-98-4115 | | 6. Sex
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday)
75 Yrs. | | 8. Date of Birth (Month, Day, Year)
12-3-1920 | |
| | 9. Birthplace (State or Foreign Country)
Pakistan | | 10a. State
Maryland | | 10b. County
Montgomery | | 10c. City, Town or Location
Bethesda | |
| To Be Completed by Funeral Director | 10d. Inside City Limits
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 10e. Street and Number
8907 Clewerwall Drive | | 10f. Zip Code
20817 | | 10g. Citizen of What Country?
USA | |
| | 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever In U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: White | |
| To Be Completed by Physician/Medical Examiner | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (1-4 or 5+) 0 | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Homemaker | | 16b. Kind of Business/Industry
Own Home | | | |
| | 17. Father's Name (First, Middle, Last)
Kartar Singh | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Rajinder Kaur | | | |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print)
Jagjeet Sidhu | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
8907 Clewerwall Drive Bethesda, MD 20817 | | | |
| | 20a. Method of Disposition
1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Baltimore Wash. Crem. | | 20c. Date
5-27-96 | | 20d. Location - City or Town, State
Laurel, Maryland | |
| To Be Completed by Physician/Medical Examiner | 21. Signature of Funeral Service Licensee
<i>[Signature]</i> | | | | 22. Name and Address of Facility
Fleck Funeral Home, Inc.
7601 Sandy Spring Road Laurel, MD 20707 | | | |
| | 23a. Part I: Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
e. <i>Cardiopulmonary Arrest</i>
Due to (or as a consequence of):
b. <i>Possible Acute Myocardial Infarction</i>
Due to (or as a consequence of):
c. <i>Atherosclerotic Coronary Artery Disease</i>
Due to (or as a consequence of):
d.

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | Approximate Interval Between Onset and Death
15 min
30 min
5 hrs | | | |
| To Be Completed by Physician/Medical Examiner | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
<i>Diabetes Mellitus, Hypertension, End Stage Renal Disease, Status Post Cerebrovascular accident, Hypothyroidism</i> | | | | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | |
| | 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | |
| To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| | 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| To Be Completed by Physician/Medical Examiner | 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| | 29a. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier
<i>[Signature]</i> | | 29c. License number
A13987 | | 29d. Date signed (Month, Day, Year)
5/23/96 | |
| To Be Completed by Physician/Medical Examiner | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
JASWINAR S. SIDHU 7525 Greenway Center Dr, Greenbelt Md 20770 | | | | 31. Date filed (Month, Day, Year)
MAY 29 1996 | | | |
| | 32. Registrar's Signature
<i>[Signature]</i> | | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at office.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene
item #19a, filmg, 736, 6/4/96,cyw
Certificate of Death

96 15855

Reg. No.

| | | | | | |
|-------------------------------------|--|--|--|---------------------------------|---|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
LED Dominic KUCZYNSKI | | 2. Date of Death
Month MAY Day 27 Year 1996 | | 3. Time of Death
12:24 PM |
| | 4a. Facility Name (If not Institution, give street and number)
Good Samaritan Hospital | | 4b. City, Town, or Location of Death
Baltimore | | 4c. County of Death
N/A |
| Funeral
Director | 5. Social Security Number
219-16-3548 | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)
72 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. |
| | 8. Date of Birth (Month, Day, Year)
July 24, 1923 | | 9. Birthplace (State or Foreign Country)
Maryland | | |
| To Be Completed by Funeral Director | Usual Residence of Decedent | | | | |
| | 10a. State
Maryland | 10b. County
Harford | 10c. City, Town or Location
Bel Air | | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |
| | 10e. Street and Number
403 Harlan Street | | 10f. Zip Code
21014 | | 10g. Citizen of What Country?
United States |
| | 11. Marital Status
<input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |
| | 14. Race - American Indian, Black, White, etc.
Specify: White | | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 8th Grade College (1-4 or 5+) | | |
| | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Laborer | | 16b. Kind of Business/Industry
Can Mfg. Company | | |
| | 17. Father's Name (First, Middle, Last)
Anthony Unknown Kuczynski | | 18. Mother's Name (First, Middle, Maiden Surname)
Alexandra Unknown Sumowski | | |
| | 19a. Informant's Name/Relationship (Type, Print)
Florence R. Oktavec (Sister) | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
403 Harlan Street Belair, Maryland 21014 | | |
| | 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Holy Rosary Cemetery | | 20c. Location - City or Town, State
Baltimore, Maryland |
| | 21. Signature of Funeral Service Licensee
 | | 22. Name and Address of Facility
John C. Miller, Inc. 6415 Belair Road Baltimore Md.-21206 | | |
| Physician
/Medical
Examiner | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. Congestive heart failure
Due to (or as a consequence of):
b. Cardiomyopathy
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d. | | | | Approximate Interval Between Onset and Death
1 WEEK
MONTHS |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |
| | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| | 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | |
| | 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day, Year) | 28b. Time of Injury
M | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| | 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | |
| | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | |
| | 29b. Signature and title of certifier

HOUSESTAFF | | 29c. License number
PO9300 | | 29d. Date signed (Month, Day, Year)
MAY 27, 1996 |
| | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
CAROLINE P. BATALLA MD - GOOD SAMARITAN HOSPITAL | | | | |
| | 31. Date filed (Month, Day, Year)
MAY 29 1996 | | 32. Registrar's Signature
 | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 96 15856

Certificate of Death

Reg. No.

| | | | | | | | | | | | | |
|--|---|---------------------------|---|---|--|---|--|--|---|--|--|---|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
ETHEL E. LADD | | | | | | 2. Date of Death
Month Day Year
MAY 26 1996 | | | 3. Time of Death
11:05pm | | |
| | 4a. Facility Name (If not institution, give street and number)
Hopkins Bayview Medical Center | | | | | | 4b. City, Town, or Location of Death
Baltimore | | | 4c. County of Death
n/a | | |
| Funeral
Director | 5. Social Security Number
220 38 6838 | | 6. Sex
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday)
54 Yrs. | | If Under 1 Year
Months Days | | If Under 24 Hrs.
Hours Min. | | 8. Date of Birth (Month, Day, Year)
Oct. 6, 1941 | 9. Birthplace (State or Foreign Country)
Maryland |
| | Usual Residence of Decedent | | | | | | | | | | | |
| 10a. State
Maryland | | 10b. County
n/a | | 10c. City, Town or Location
Baltimore | | | | | | 10d. Inside City Limits
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | |
| 10e. Street and Number
6601 Gary Ave. | | | | 10f. Zip Code
21224 | | | | 10g. Citizen of What Country?
United States | | | | |
| 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced | | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc.
Specify: White | | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 8 College (1-4or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Homemaker | | | | 16b. Kind of Business/Industry
Domestic | | | | |
| 17. Father's Name (First, Middle, Last)
Arthur F. Heck | | | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Ethel A. Seabrease | | | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
Ethel A. Heck / mother | | | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
524 N. Charles St., Baltimore, MD 21201 | | | | | | |
| 20a. Method of Disposition
1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Green Mount Crematory | | | | Date
5/28/96 | | 20c. Location - City or Town, State
Baltimore, MD | | |
| 21. Signature of Funeral Service Licensee
 | | | | | | 22. Name and Address of Facility
CAFA Stephen D. Lohrmann P.A.
8717 Green Pastures Dr., Baltimore, MD 21286 | | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

a. Anoxic Brain Damage
Due to (or as a consequence of):

b. Myocardial Infarction
Due to (or as a consequence of):

c. Chronic Obstructive Lung Disease
Due to (or as a consequence of):

d.

Approximate Interval Between Onset and Death
2 weeks
2 weeks
10 years | | | | | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Non-Insulin Dependent Diabetes Mellitus
Neuromuscular Disorder | | | | | | | | | | | | |
| 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | 26. Place of Death (Check only one)
Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide
5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how Injury occurred | | |
| 29a. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | 29b. Signature and title of certifier
 | | | | 29c. License number
M6156 | | 29d. Date signed (Month, Day, Year)
MAY 26, 1996 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
4940 EASTERN AVE BALTIMORE, MD 21224 | | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
MAY 29 1996 | | | | | | | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
JAMES P. MORGAN, SR. | | | | 2. DATE OF DEATH
MONTH DAY YEAR
May 28, 1996 | | 3. TIME OF DEATH
4:45 A. | |
| 4. SOCIAL SECURITY NUMBER
216-01-4276 | | 5. SEX
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (in yrs. last birthday)
84 YRS. | | 7. DATE OF BIRTH (Month, Day, Year)
March 9, 1912 | |
| 8. BIRTHPLACE (State or Foreign Country)
Maryland | | | | 9a. FACILITY NAME (If not institution, give street and number)
Greater Baltimore Medical Center | | 9b. CITY, TOWN OR LOCATION OF DEATH
Towson | |
| 9c. COUNTY OF DEATH
Baltimore | | | | 10a. STATE
Maryland | | 10b. COUNTY
N/A | |
| 10c. CITY, TOWN OR LOCATION
Baltimore | | | | 10d. INSIDE CITY LIMITS?
<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | 10e. STREET AND NUMBER
2601 Roselawn Avenue | |
| 10f. ZIP CODE
21214 | | | | 10g. CITIZEN OF WHAT COUNTRY?
United States | | 11. MARITAL STATUS
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12) 1 College (1-4 or 5+) 1 | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
First Class Engineer | | 16b. KIND OF BUSINESS/INDUSTRY
Industrial | |
| 17. FATHER'S NAME (First, Middle, Last)
John J. Morgan | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Margaret J. McKenna | | | |
| 19a. INFORMANT'S NAME (Type/Print)
Mrs. Patricia Hellman | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
7408 Gum Spring Road Baltimore, Md. 21237 | | | |
| 20a. METHOD OF DISPOSITION
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
Parkwood Cemetery 5/31/96 | | 20c. LOCATION — City or Town, State
Baltimore, Maryland | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
Mark T. Zavovna | | | | 22. NAME AND ADDRESS OF FACILITY
5305 Harford Road Leonard J. Ruck, Inc. Baltimore, Md. 21214 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. myocardial infarction. | | | | | | | |
| DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | |
| b. gt bleeding. | | | | | | | |
| DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| c. thrombosis of left femoral popliteal bypass | | | | | | | |
| DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| d. | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | | | | |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
<input type="checkbox"/> YES <input type="checkbox"/> NO | | | | | | | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA
OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | |
| 27. MANNER OF DEATH
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation
<input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Could not be determined | | | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M | |
| 28c. INJURY AT WORK?
<input type="checkbox"/> YES <input type="checkbox"/> NO | | | | 28d. DESCRIBE HOW INJURY OCCURRED | | | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one)
<input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
Laurence H. Ross | | | | 29c. LICENSE NUMBER
035707 | | 29d. DATE SIGNED (Month, Day, Year)
5/20/96 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
Laurence H. Ross, M.D. 1205 York Road Lutherville, Maryland 21093 | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
MAY 29 1996 | | | | 32. REGISTRAR'S SIGNATURE
Wilson-Randall | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

96 15858

Filmg, 735, item 19a,19b, 5/29/96,cyw, per fh

FOR
1 - STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|---|--|---|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last)
<i>Virginia L. Moran</i> | | | | 2. DATE OF DEATH
MONTH DAY YEAR
<i>MAY 21 96</i> | | 3. TIME OF DEATH
<i>1809</i> | |
| 4. SOCIAL SECURITY NUMBER
<i>184-58-2136</i> | | 5. SEX
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
<i>19</i> YRS. | | 7. DATE OF BIRTH
(Month, Day, Year)
<i>Apr 30 77</i> | |
| 8. BIRTHPLACE (State or Foreign Country)
<i>CARBONDALE, PA</i> | | | | 9a. FACILITY NAME (If not institution, give street and number)
<i>North Arundel Hosp</i> | | | |
| 9b. CITY, TOWN OR LOCATION OF DEATH
<i>Glen Burnie</i> | | | | 9c. COUNTY OF DEATH
<i>AA</i> | | | |
| 10a. STATE
<i>MD</i> | | 10b. COUNTY
<i>ANNE ARUNDEL</i> | | 10c. CITY, TOWN OR LOCATION
<i>GLEN BURNIE</i> | | 10d. INSIDE CITY LIMITS?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 10e. STREET AND NUMBER
<i>8178 GREAT BEND ROAD</i> | | | | 10f. ZIP CODE
<i>21061</i> | | 10g. CITIZEN OF WHAT COUNTRY?
<i>U.S.A.</i> | |
| 11. MARITAL STATUS
<input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
If YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify: <i>WHITE</i> | |
| 15. DECEDENT'S EDUCATION
(Specify only highest grade completed)
<i>12TH GRADE</i> | | 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.)
<i>SALES</i> | | 16b. KIND OF BUSINESS/INDUSTRY
<i>RETAIL SALES</i> | | | |
| 17. FATHER'S NAME (First, Middle, Last)
<i>JAMES PATRICK MORAN</i> | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
<i>GERRY JONES</i> | | | |
| 19a. INFORMANT'S NAME (Type/Print)
<i>GERALDINE MORAN</i> | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
<i>10455 OWEN BROWN RD, COLUMBIA, MD, 21044</i> | | | | | |
| 20a. METHOD OF DISPOSITION
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
<i>PROSPECT HILLS CEMETERY</i> | | 20c. LOCATION — City or Town, State
<i>5/25 PECKVILLE, PA.</i> | | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
<i>[Signature]</i> | |
| 22. NAME AND ADDRESS OF FACILITY
<i>HUBBARD FUNERAL HOME INC.</i> | | 4107 WILKENS AVENUE-BALTIMORE, MD 21229 | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Guns shot wound Chest</i>
DUE TO (OR AS A CONSEQUENCE OF):
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. DUE TO (OR AS A CONSEQUENCE OF):
c. DUE TO (OR AS A CONSEQUENCE OF):
d. | | | | | | | Approximate interval Between Onset and Death
<i>minutes</i> |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
<i>DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></i> | | | | | | | 24a. WAS AN AUTOPSY PERFORMED?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA
OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | 27. MANNER OF DEATH
<input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation
<input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year)
<i>5/21/96</i> | |
| 28b. TIME OF INJURY
<i>1715</i> | | 28c. INJURY AT WORK?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED
<i>Shot self.</i> | | | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
<i>Home</i> | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
<i>Glen Burnie, md</i> | | | | | |
| 29a. CERTIFIER (Check only one)
<input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. SIGNATURE AND TITLE OF CERTIFIER
<i>William P. Jones, MD Deputy</i> | | 29c. LICENSE NUMBER
<i>D 06054</i> | | 29d. DATE SIGNED (Month, Day, Year)
<i>5/22/96</i> | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
<i>William P. Jones, MD 695 America 21035</i> | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
<i>MAY 29 1996</i> | | 32. REGISTRAR'S SIGNATURE
<i>John Andrew Ruskell</i> | | | | | |

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

item #1, filmg 736, 6/7/96,cyw

96 15859

Certificate of Death

Reg. No.

| | | | | | | | | | | | |
|---|---|---|--|---|--|--|--|---|---|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
LUCINDA MILLER MILLER | | | | | | 2. Date of Death
Month Day Year
MAY 27, 1996 | | | 3. Time of Death
6:50 A.M. | |
| | 4a. Facility Name (If not institution, give street and number)
THE JOHNS HOPKINS HOSPITAL | | | | | | 4b. City, Town, or Location of Death
BALTIMORE CITY | | | 4c. County of Death
N/A | |
| Funeral
Director | 5. Social Security Number
265-32-6309 | | 6. Sex
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday)
74 Yrs. | | 8. Date of Birth (Month, Day, Year)
JAN 16, 1922 | | 9. Birthplace (State or Foreign Country)
GA | | |
| | 10e. State
MD | | 10b. County
N/A | | 10c. City, Town or Location
BALTIMORE | | 10d. Inside City Limits
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | |
| 10e. Street and Number
2562 CECIL AVE | | 10f. Zip Code
21218 | | 10g. Citizen of What Country?
U.S.A. | | 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 6th
College (1-4 or 5+) N/A | | 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
ELEVATOR OPERATOR | | 16b. Kind of Business/Industry
HOSPITAL | | 14. Race - American Indian, Black, White, etc.
Specify: BLACK | | | | | |
| 17. Father's Name (First, Middle, Last)
BENNIE JONES | | | | | | 18. Mother's Name (First, Middle, Maiden Surname)
MAMMIE SIMMONS | | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
JOHNNIE MAE JONES/DAUGHTER | | | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
2562 CECIL AVE BALTO, MD 21218 | | | | | |
| 20e. Method of Disposition
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
MD NATIONAL CEM | | Date
JUNE 1, 96 | | 20c. Location - City or Town, State
LAUREL, MD | | | |
| 21. Signature of Funeral Service Licensee
<i>Patricia Butts</i> | | | | 22. Name and Address of Facility
BETTS FUNERAL HOME
1129 N. CAROLINE ST BALTO, MD 21213 | | | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. <i>Gram Negative Septicaemia.</i>
Due to (or as a consequence of):
b. <i>metastatic Breast Cancer.</i>
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | | | | | |
| 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | | | | | | | | | |
| 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | | | | |
| 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | | | | | |
| 26. Place of Death (Check only one)
Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | | | | | |
| 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide
5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | | | |
| | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | | | | |
| 29b. Signature and title of certifier
<i>Dr. Annela Yagoub / A. Yagoub M.D.</i> | | | | | | 29c. License number
N 8678. | | 29d. Date signed (Month, Day, Year)
May 27th 1996. | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Oncology Centre 3A Johns Hopkins Hospital. | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
MAY 29 1996 | | 32. Registrar's Signature
<i>Anderson-Rendell</i> | | | | | | | | | |

Baltimore, Maryland 21215-0020

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 15860

Certificate of Death

Reg. No.

| | | | | | | | | | | |
|---|---|---|--|--|--------------------------------|---|---|--|---|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Joann E. Melhorn | | | | | | 2. Date of Death
Month MAY Day 23 Year 96 | | 3. Time of Death
13:49 | |
| | 4a. Facility Name (If not institution, give street and number)
ST. AGNES HOSPITAL | | | | | | 4b. City, Town, or Location of Death
BALTIMORE | | 4c. County of Death
BALTIMORE CITY | |
| Funeral
Director | 5. Social Security Number
214-12-3969 | | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)
74 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth (Month, Day, Year)
JUNE 23, 1921 | | 9. Birthplace (State or Foreign Country)
PENNSYLVANIA | |
| | Usual Residence of Decedent | | | | | | | | | |
| 10a. State
MD | | 10b. County
BALTIMORE CITY | | 10c. City, Town or Location
BALTIMORE | | | | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | |
| 10e. Street and Number
3424 7TH STREET | | | | 10f. Zip Code
21225 | | 10g. Citizen of What Country?
U.S.A. | | | | |
| 11. Marital Status
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc.
Specify: WHITE | | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 7TH GRADE | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
CASHIER | | | 16b. Kind of Business/Industry
RITE AID | | | |
| 17. Father's Name (First, Middle, Last)
JAMES G. HYATT | | | | | | 18. Mother's Name (First, Middle, Maiden Surname)
LELIA CAHALL | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
LELIA EATON (NIECE) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
RT 1, BOX 653-D - RAPHAINE, VIRGINIA 24472 | | | | | | |
| 20a. Method of Disposition
<input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
HILLTOP SERVICE CORP. | | Date
5/25/96 | | 20c. Location - City or Town, State
TOWSON | | |
| 21. Signature of Funeral Service Licensee
 | | | | 22. Name and Address of Facility
HUBBARD FUNERAL HOME, INC.
4107 WILKENS AVENUE-BALTIMORE, MD 21229 | | | | | | |
| 23. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | | | | Approximate Interval Between Onset and Death |
| Immediate Cause (Final disease or condition resulting in death)
e. MULTIORGAN FAILURE
Due to (or as a consequence of): | | | | | | | | | | one day. |
| Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. SEPSIS.
Due to (or as a consequence of): | | | | | | | | | | two days. |
| c. _____
Due to (or as a consequence of): | | | | | | | | | | |
| d. _____
Due to (or as a consequence of): | | | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | |
| | | | | | | | | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| | | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury et Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | | |
| | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier
 MD | | | | 29c. License number
P09884 | | 29d. Date signed (Month, Day, Year)
MAY 23 1996 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
DR. K. VENKATARAM. ST. AGNES HOSPITAL 900 GATON AVE. BALTIMORE. | | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
MAY 29 1996 | | 32. Registrar's Signature
 | | | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

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Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 15861

Certificate of Death

Reg. No.

| | | | | | | | | |
|--|---|--|---|--|---|---|---|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Michael L. Matuszewski Jr. | | | | 2. Date of Death
Month Day Year
May 23 1996 | | 3. Time of Death
UNKNOWN | |
| | 4a. Facility Name (If not Institution, give street and number)
7654 Bay Drive | | | | 4b. City, Town, or Location of Death
Pasadena | | 4c. County of Death
Anne Arundel | |
| Funeral
Director | 5. Social Security Number
216-34-0529 | | 6. Sex
1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 7. Age (In yrs. last birthday)
58 Yrs. | | 8. Date of Birth (Month, Day, Year)
April 17, 1938 | |
| | 9. Birthplace (State or Foreign Country)
Maryland | | 10. Usual Residence of Decedent | | 11. Marital Status
1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | |
| To Be Completed by Funeral Director | 10a. State
Maryland | | 10b. County
Anne Arundel | | 10c. City, Town or Location
Pasadena | | 10d. Inside City Limits
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | |
| | 10e. Street and Number
7654 Bay Drive | | | | 10f. Zip Code
21122 | | 10g. Citizen of What Country?
United States | |
| | 11. Marital Status
1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: White | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) College (1-4 or 5+) 4 | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Draftsman | | 16b. Kind of Business/Industry
Defense | | | |
| | 17. Father's Name (First, Middle, Last)
Michael L. Matuszewski, Sr. | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Margaret Ann Sadler | | | |
| | 19a. Informant's Name/Relationship (Type, Print)
Mrs. Patricia Taylor/Sister | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
39 Chester Circle Pasadena, MD 21122 | | | |
| | 20a. Method of Disposition
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Holy Cross Cem. May 28, 1996 | | 20c. Location - City or Town, State
Brooklyn Park, Maryland | | | |
| | 21. Signature of Funeral Service Licensee
L. E. Bough | | | | 22. Name and Address of Facility
Kirkley-Ruddick Funeral Home
421 Crain Hwy., S.E., Glen Burnie, MD 21061 | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
Immediate Cause (Final disease or condition resulting in death)
a. Sudden Death presumed Myocardial Infarction
Due to (or as a consequence of):
b. atherosclerotic cardiovascular disease
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d. | | | | | | | |
| | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | | | | | |
| 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | | | | |
| Medical Certification: To Be Completed by Physician/Medical Examiner | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Hypertension
Diabetes Mellitus type II | | | | | | | |
| | 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | |
| | 26. Place of Death (Check only one)
Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | |
| | 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide
5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| | 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | |
| 29b. Signature and title of certifier
Michael F. Garahy | | | | 29c. License number
021703 | | 29d. Date signed (Month, Day, Year)
May 24, 1996 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Michael F. Garahy, M.D., 8651 Ft. Smallwood Rd., Pasadena, Maryland 21122 | | | | | | | | |
| 31. Date filed (Month, Day, Year)
MAY 29 1996 | | | | 32. Registrar's Signature
John Davidson-Randall | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

15

THE UNIVERSITY OF CHICAGO

DEPARTMENT OF CHEMISTRY

LABORATORY OF ORGANIC CHEMISTRY

CHICAGO, ILLINOIS

1955

RECEIVED

FROM

DATE

BY

REMARKS

1. 2. 3. 4. 5. 6. 7. 8. 9. 10.

11. 12. 13. 14. 15. 16. 17. 18. 19. 20.

21. 22. 23. 24. 25. 26. 27. 28. 29. 30.

31. 32. 33. 34. 35. 36. 37. 38. 39. 40.

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101. 102. 103. 104. 105. 106. 107. 108. 109. 110.

111. 112. 113. 114. 115. 116. 117. 118. 119. 120.

121. 122. 123. 124. 125. 126. 127. 128. 129. 130.

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State of Maryland / Department of Health and Mental Hygiene

96 15862

Certificate of Death

Reg. No.

| | | | | | | | | | | | | | | |
|---|---|---------------------------|---|---|---|--|--------------------------------|--|---|--|--|--|---|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Margaret C. McCosker | | | | 2. Date of Death
Month May Day 27 Year 1996 | | | | 3. Time of Death
4:05 am | | | | | |
| | 4a. Facility Name (If not institution, give street and number)
STELLA MARIS HOSPICE | | | | 4b. City, Town, or Location of Death
TOWSON | | | | 4c. County of Death
BALTIMORE | | | | | |
| Funeral
Director | 5. Social Security Number
215-01-2171 | | 6. Sex
1 <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday)
90 Yrs. | | If Under 1 Year
Months Days | | If Under 24 Hrs.
Hours Min. | | 8. Date of Birth (Month, Day, Year)
02-02-1906 | | 9. Birthplace (State or Foreign Country)
MARYLAND | |
| | Usual Residence of Decedent | | | | | | | | | | | | | |
| 10a. State
MD. | | 10b. County
N/A | | 10c. City, Town or Location
BALTIMORE CITY | | | | | | | | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | |
| 10e. Street and Number
2206 TELHAM AVENUE | | | | 10f. Zip Code
21213 | | | | 10g. Citizen of What Country?
U.S.A. | | | | | | |
| 11. Marital Status
<input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc.
Specify: WHITE | | | | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 4 YEARS | | | | 18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
TECHNICAL RECORD EXAMINER | | | | 16b. Kind of Business/Industry
SOCIAL SECURITY ADMINISTRATION | | | | | | |
| 17. Father's Name (First, Middle, Last)
HENRY McCOSKER | | | | | | 18. Mother's Name (First, Middle, Maiden Summa)
NELLIE CAMPBELL | | | | | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
CATHERINE A. CRAIG (NIECE) | | | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
2206 TELHAM AVENUE, BALTIMORE, MD., 21213 | | | | | | | | |
| 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
NEW CATHEDRAL CEM. | | | | Data
5-31 | | 20c. Location - City or Town, State
BALTO., MD., 21229 | | | | |
| 21. Signature of Funeral Service Licensee
 | | | | | | 22. Name and Address of Facility
HENRY W. JENKINS AND SONS COMPANY
4905 YORK ROAD, BALTIMORE, MARYLAND, 21212 | | | | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. Cerebrovascular Accident
Due to (or as a consequence of):

b.
Due to (or as a consequence of):

c.
Due to (or as a consequence of):

d. | | | | | | | | | | | | Approximate Interval Between Onset and Death | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | | | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown | | | | |
| | | | | | | | | | | 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | |
| | | | | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | |
| 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one)
Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | | | | |
| 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation
2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined
3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how Injury occurred | | | | |
| | | | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | |
| 29a. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | | | | | | | |
| 29b. Signature and title of certifier
 | | | | | | 29c. License number
15862 | | 29d. Date signed (Month, Day, Year)
5-28-96 | | | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Eddie Nakhuda, M.D. 2300 Dulaney Valley Road, Baltimore, Maryland 21204 | | | | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
MAY 29 1996 | | | | 32. Registrar's Signature
 | | | | | | | | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

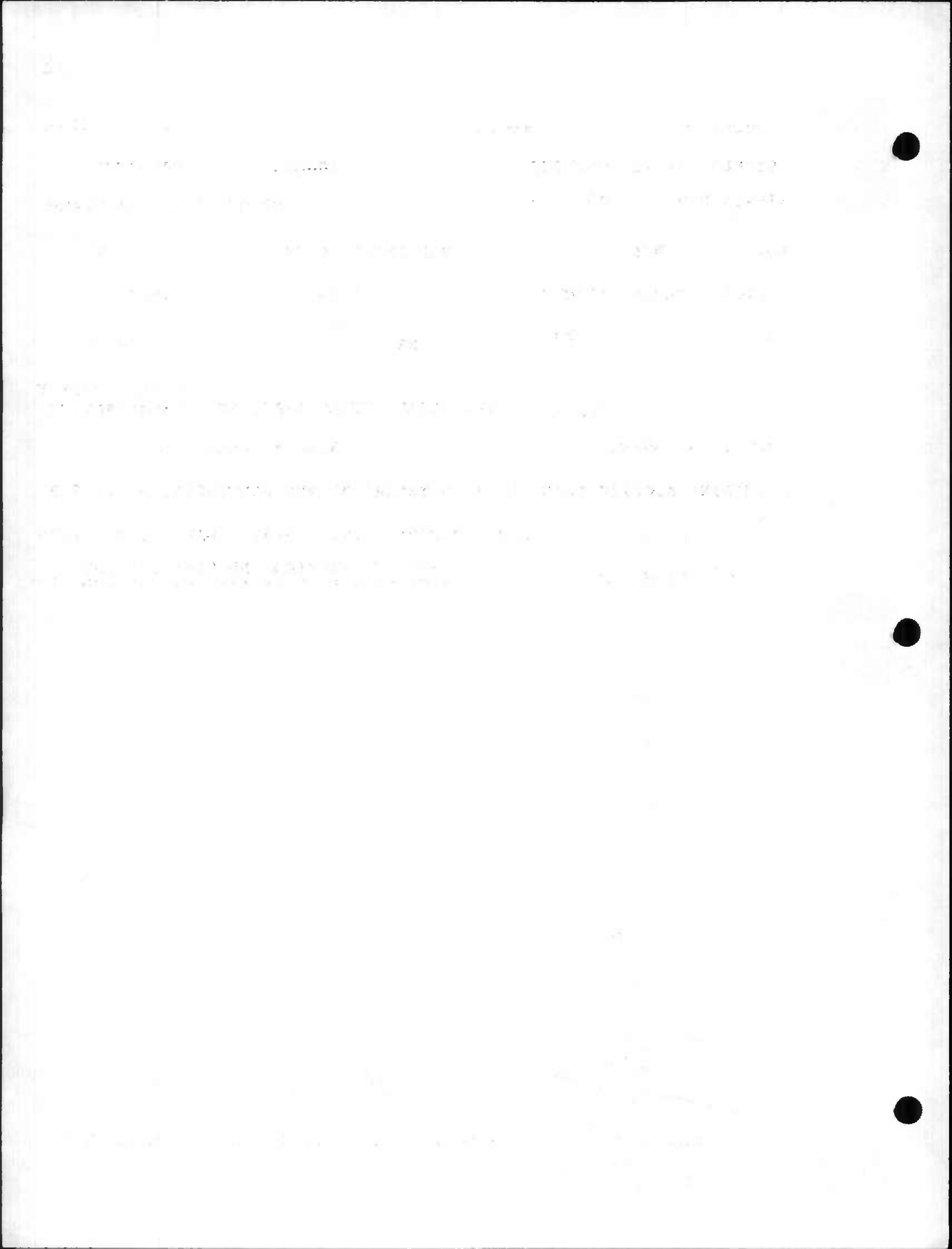
Physician
/Medical
Examiner

To the Registrar or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

5

State
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.


State of Maryland / Department of Health and Mental Hygiene

96 15863

Certificate of Death

Reg. No.

| | | | | | | | | | | | | | | | | | |
|---|---|---|--|--|---|--|---|---|--|---|--|---|-----------------|---|----------------|----------|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
ANDRE MICHAEL MARTIN | | | | 2. Date of Death
Month Day Year
MAY 24, 1996 | | 3. Time of Death
00:20 | | | | | | | | | | |
| | 4a. Facility Name (If not institution, give street and number)
THE JOHNS HOPKINS HOSPITAL | | | | 4b. City, Town, or Location of Death
BALTIMORE CITY | | 4c. County of Death | | | | | | | | | | |
| Funeral
Director | 5. Social Security Number
215-74-8143 | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday)
39 Yrs. | | 8. Date of Birth (Month, Day, Year) | | | | | | | | | | |
| | 9. Birthplace (State or Foreign Country)
MARYLAND | | 10a. State
MARYLAND | | 10b. County
BALTIMORE | | 10c. City, Town or Location
BALTIMORE | | | | | | | | | | |
| 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 10e. Street and Number
234 HERRING COURT | | 10f. Zip Code
21231 | | 10g. Citizen of What Country?
USA | | | | | | | | | | | |
| 11. Marital Status
<input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: BLACK | | | | | | | | | | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 8 College (1-4 or 5+) Collega (1-4 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
COOK | | 16b. Kind of Business/Industry
UNIVERSITY OF MD HOSPITAL | | | | | | | | | | | | | |
| 17. Father's Name (First, Middle, Last)
JOHN H. MARTIN | | | | 18. Mother's Name (First, Middle, Maiden Surname)
LORRAINE GRAVES | | | | | | | | | | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
LORRAINE MARTIN / MOTHER | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
234 HERRING COURT BALTIMORE, MD 21231 | | | | | | | | | | | | | |
| 20a. Method of Disposition
<input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
KING MEMORIAL PARK | | 20c. Location - City or Town, State
BALTIMORE CO, MD | | | | | | | | | | | | | |
| 21. Signature of Funeral Service Licensee
 | | | | 22. Name and Address of Facility
NUTTER FUNERAL HOMES, INC
2501 GWYNNS FALLS PKWY BALTO., MD 21216 | | | | | | | | | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

<table border="0"> <tr> <td>Immediate Cause (Final disease or condition resulting in death)</td> <td>a. <u>Aspiration Pneumonia</u>
Due to (or as a consequence of):</td> <td>Approximate Interval Between Onset and Death
12 hours</td> </tr> <tr> <td rowspan="3">Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last</td> <td>b. <u>Left basal ganglia mass</u>
Due to (or as a consequence of):</td> <td>3 months</td> </tr> <tr> <td>c. <u>Acquired Immundeficiency Syndrome</u>
Due to (or as a consequence of):</td> <td>2 years</td> </tr> <tr> <td>d. _____</td> <td></td> </tr> </table> | | | | | | | | Immediate Cause (Final disease or condition resulting in death) | a. <u>Aspiration Pneumonia</u>
Due to (or as a consequence of): | Approximate Interval Between Onset and Death
12 hours | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. <u>Left basal ganglia mass</u>
Due to (or as a consequence of): | 3 months | c. <u>Acquired Immundeficiency Syndrome</u>
Due to (or as a consequence of): | 2 years | d. _____ | |
| Immediate Cause (Final disease or condition resulting in death) | a. <u>Aspiration Pneumonia</u>
Due to (or as a consequence of): | Approximate Interval Between Onset and Death
12 hours | | | | | | | | | | | | | | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. <u>Left basal ganglia mass</u>
Due to (or as a consequence of): | 3 months | | | | | | | | | | | | | | | |
| | c. <u>Acquired Immundeficiency Syndrome</u>
Due to (or as a consequence of): | 2 years | | | | | | | | | | | | | | | |
| | d. _____ | | | | | | | | | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | | | | | | | |
| | | | | | | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | | | | |
| | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | | | | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | | | | | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | | | | |
| | | 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | | | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | | | | | | | | |
| 29b. Signature and title of certifier
Sherita A Hill, MD Housestaff | | | | 29c. License number
M6279 | | 29d. Date signed (Month, Day, Year)
MAY 24, 1996 | | | | | | | | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Dr. Sherita A. Hill Tower 110 Doctor's Lounge Johns Hopkins Hospital Baltimore, MD 21287 | | | | | | | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
MAY 29 1996 | | | | 32. Registrar's Signature
 | | | | | | | | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 15864

Certificate of Death

Reg. No.

| | | | | | | | | |
|--|--|--|---|-------------------------------|---|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Alice P Olstad | | | | 2. Date of Death
Month Day Year
May 22, 1996 | | 3. Time of Death
2:50am | |
| | 4a. Facility Name (If not Institution, give street and number)
Collington Lifecare Center | | | | 4b. City, Town, or Location of Death
Mitchellville | | 4c. County of Death
Prince George | |
| Funeral
Director | 5. Social Security Number
099-24-4345 | | 6. Sex
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday)
83 Yrs. | | 8. Date of Birth (Month, Day, Year)
JUNE 18, 1912 | |
| | 9. Birthplace (State or Foreign Country)
Missouri | | 10a. State
Md. | | 10b. County
Prince George | | 10c. City, Town or Location
Mitchellville | |
| To Be Completed by Funeral Director | 10d. Inside City Limits
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 10e. Street and Number
10450 Lottsford Rd. | | 10f. Zip Code
20721 | | 10g. Citizen of What Country?
USA | |
| | 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever In U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: white | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) College (1-4 or 5+) 4 | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Registered Nurse | | 16b. Kind of Business/Industry
School Nurse | | | |
| | 17. Father's Name (First, Middle, Last)
Charles Makarevich | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Katherine Matsinkute | | | |
| | 19a. Informant's Name/Relationship (Type, Print)
Martin H. Olstad - husband | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
10450 Lottsford Rd., Mitchellville, Md. 20721 | | | |
| | 20a. Method of Disposition
1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
The Green Mount Cemetery | | 20c. Date
5/25/96 | | 20d. Location - City or Town, State
Baltimore, Md. | |
| | 21. Signature of Funeral Service Licensee
 | | | | 22. Name and Address of Facility
Gary L. Kaufman Funeral Home of Elk., Inc.
5695 Main St., ElkrIDGE, Md. 21227 | | | |
| | 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
Immediate Cause (Final disease or condition resulting in death)
a. Cardiopulmonary arrest
Due to (or as a consequence of):
b. Adenocarcinoma lung
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.
Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | |
| | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | | | | | |
| | 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | |
| Medical Certification: To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one)
Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify) | | | |
| | 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation
2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined
3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| | 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| | 29a. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | |
| State Registrar | 29b. Signature and Title of certifier
 | | | | 29c. License number
D34231 | | 29d. Date signed (Month, Day, Year)
May 22, 1996 | |
| | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Robin L. Bissell, M.D., 8911 - 60th Avenue, College Park, Maryland 20740 | | | | | | | |
| 31. Date filed (Month, Day, Year)
MAY 29 1996 | | | | 32. Registrar's Signature
 | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 96 15865

Certificate of Death

Reg. No.

| | | | | | | | | | | |
|---|--|--|---|---|---|---|---|---|---|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
CARMEN P. PETTINATO | | | | 2. Date of Death
Month May Day 26 Year 1996 | | | | 3. Time of Death
3:25 p.m. | |
| | 4a. Facility Name (If not institution, give street and number)
V.A. MEDICAL CENTER, FORT HOWARD, MARYLAND 21052 ft. Howard | | | | 4b. City, Town, or Location of Death
Baltimore | | | | 4c. County of Death
Baltimore | |
| Funeral
Director | 5. Social Security Number
212-30-4070 | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday)
62 Yrs. | | 8. Date of Birth (Month, Day, Year)
Dec. 24, 1933 | | 9. Birthplace (State or Foreign Country)
Redbank, N.J. | |
| | 10a. State
Md. | | | | 10b. County
Allegany | | 10c. City, Town or Location
Cumberland | | | |
| To Be Completed by Funeral Director | 10e. Street and Number
P. O. Box 841 - 523 Henderson Ave. | | | | 10f. Zip Code
21501 | | 10g. Citizen of What Country?
USA | | | |
| | 11. Marital Status
<input type="checkbox"/> Navar Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc.
Specify: white | | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 8 | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Skilled Ice Cream Maker | | 16b. Kind of Business/Industry
Safeway | | | | | |
| | 17. Father's Name (First, Middle, Last)
Pete Pettinato | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Rosemarie (Unobtainable) | | | | | |
| | 19a. Informant's Name/Relationship (Type, Print)
Nellie Mae Pettinato - wife | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1337 E. Patapsco Ave., Balto., Md. 21225 | | | | | |
| | 20a. Method of Disposition
<input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
The Green Mount Cemetery | | Data
5/29/96 | | 20c. Location - City or Town, State
Balto., Md. | | | |
| | 21. Signature of Funeral Service Licensee
<i>Jackie H. Shannon</i> | | | | 22. Name and Address of Facility
Gary L. Kaufman Funeral Home of Elk., Inc.
5695 Main St., ElkrIDGE, Md. 21227 | | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. Lung Cancer
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. | | | | | | | | Approximate interval Between Onset and Death
2 months | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Cachexia | | | | | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | |
| | 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | 26. Place of Death (Check only one)
Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation
<input type="checkbox"/> Accident <input type="checkbox"/> Suicide
<input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | 28a. Date of injury (Month, Day, Year) | | 28b. Time of injury
M | | 28c. Injury at work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | 29b. Signature and title of certifier
<i>Shannon</i> | | 29c. License number
D 30528 | | 29d. Date signed (Month, Day, Year)
5/26/96 May 26 1996 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
DR. DUGGIRALA, BALA M.D. 9600 NORTH POINT ROAD, FORT HOWARD, MARYLAND 21052 | | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
MAY 29 1996 | | | | | 32. Registrar's Signature
<i>[Signature]</i> | | | | | |

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 15866

Certificate of Death

Reg. No.

| | | | | | | | |
|---|---|--|---|---|--|--|---|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
VICTORIA ANTOINETTE PIERPOINT | | | | 2. Date of Death
Month May Day 26 Year 1996 | | 3. Time of Death
8:00 A.M. |
| | 4a. Facility Name (If not institution, give street and number)
386 Riverside Drive | | | | 4b. City, Town, or Location of Death
Pasadena | | 4c. County of Death
Anne Arundel |
| Funeral
Director | 5. Social Security Number
215 10 7017 | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)
77 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth (Month, Day, Year)
June 12, 1918 | |
| | 9. Birthplace (State or Foreign Country)
Maryland | | | | | | |
| To Be Completed by Funeral Director | Usual Residence of Decedent | | | | | | |
| | 10a. State
MD | 10b. County
Anne Arundel | | 10c. City, Town or Location
Pasadena | | 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| | 10e. Street and Number
386 Riverside Drive | | | 10f. Zip Code
21122 | | 10g. Citizen of What Country?
U.S. | |
| | 11. Marital Status
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: White |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (1-4 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Homemaker | | 16b. Kind of Business/Industry
Own Home | | |
| | 17. Father's Name (First, Middle, Last)
Victor Monkus | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Monica Simonodicius | | |
| | 19a. Informant's Name/Relationship (Type, Print)
James Pierpoint (son) | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
417 Sylvview Dr. Pasadena, MD 21122 | | | |
| | 20a. Method of Disposition
<input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Metro Crematory | | Date
5-28-96 | 20c. Location - City or Town, State
Catonsville MD | |
| | 21. Signature of Funeral Service Licensee
 | | | 22. Name and Address of Facility
Gonce Funeral Home P.A.
4001 Ritchie Highway Baltimore, Md. 21225 | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

e. Cardiorespiratory Arrest
Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Metastatic COLON CANCER | | | | | | |
| Approximate Interval Between Onset and Death
1 YEAR | | | | | | | |
| Physician
/Medical
Examiner | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
MYASTHENIA GRAVIS, HYPERTENSION | | | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |
| | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| | 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |
| | 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation
<input type="checkbox"/> Accident <input type="checkbox"/> Suicide
<input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | 28c. Injury at Work?
<input type="checkbox"/> Yes <input type="checkbox"/> No | |
| | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28d. Describe how injury occurred | | |
| | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | |
| | 29e. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | |
| | 29b. Signature and title of certifier
Candace Irene Chandler MD | | | 29c. License number
D29209 | | 29d. Date signed (Month, Day, Year)
5/27/96 | |
| | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
CANDACE CHANDLER 8096 EDWIN RAYNOR BLVD PASADENA MD 21122 | | | | | | |
| | 31. Date filed (Month, Day, Year)
MAY 29 1996 | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

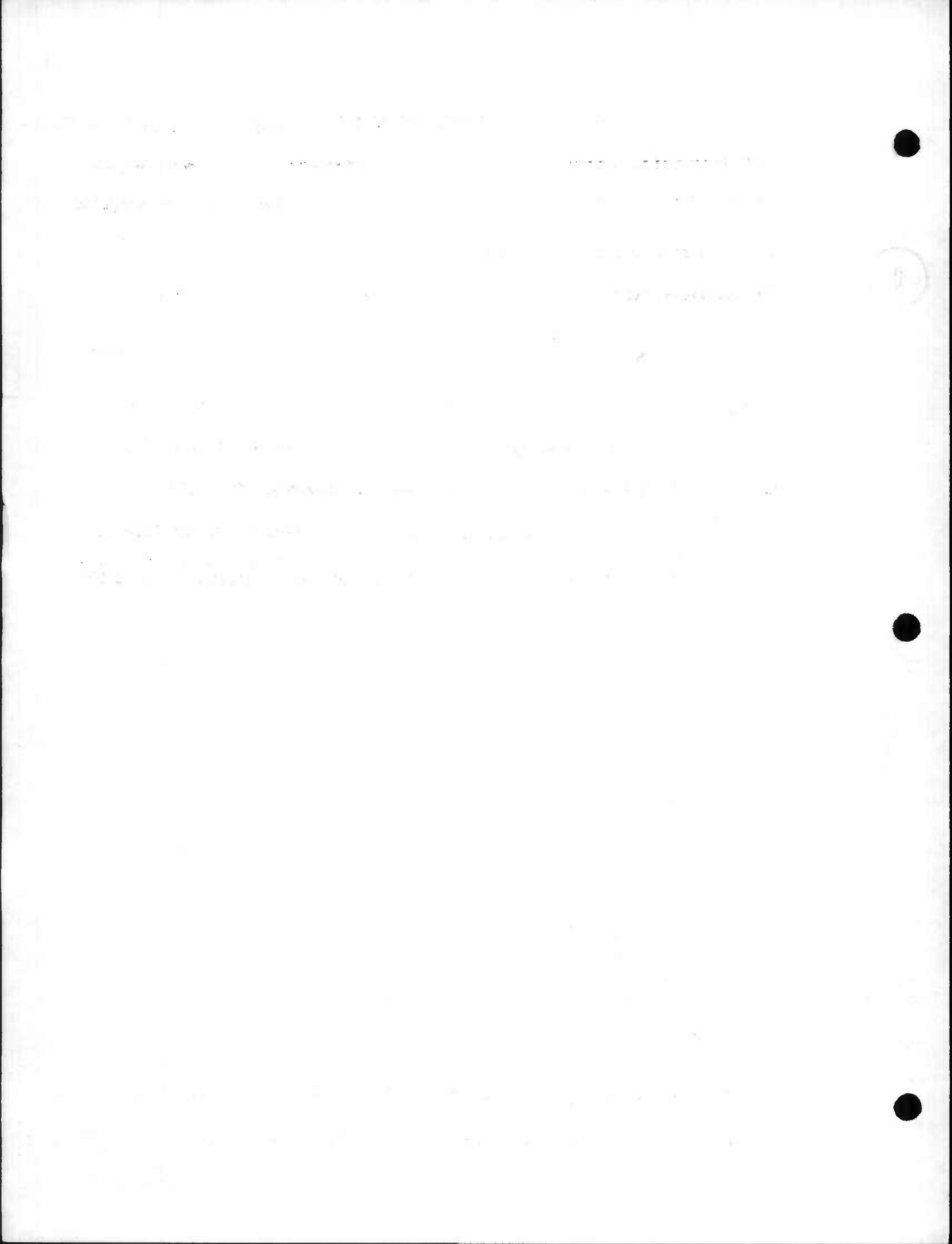
6

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 15867

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

LILLIE BELLE PETERSON

2. Date of Death

MAY 26 1996

3. Time of Death

7:30 PM

4a. Facility Name (If not Institution, give street and number)

HARBOR HOSPITAL CENTER

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

BALTIMORE

Funeral
Director

5. Social Security Number

213 14 8945

6. Sex

1 ☐ M ☒ F

7. Age (In yrs. last birthday)

74 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

OCT. 1, 1921

9. Birthplace (State or Foreign Country)

SOUTH CAROLINA

Usual Residence of Decedent

10a. State

MD.

10b. County

N/A

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

2812 BOOKERT DRIVE

10f. Zip Code

21225

10g. Citizen of What Country?

U.S. OF A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: BLACK

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12TH

College (1-4 or 5+)

N/A

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

SCHOOL CROSSING GUARD

16b. Kind of Business/Industry

SCHOOL
BALTO. CITY PUBLIC

17. Father's Name (First, Middle, Last)

WILLIAM CARTER

18. Mother's Name (First, Middle, Maiden Surname)

MAMIE EDWARDS

19a. Informant's Name/Relationship (Type, Print)

MR. HAROLD PETERSON (SON)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2812 BOOKERT DRIVE BALTO., MD. 21225

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

GARRISON FOREST VET. CEM.

Date

5/31/96

20c. Location - City or Town, State

BALTO.
OWINGS MILLS, MD. CO.

21. Signature of Funeral Service Licensee

LEWIS T. GWYNN
Lewis T. Gwynn

22. Name and Address of Facility

LEWIS T. GWYNN FUNERAL HOME 21215
4517 PARK HEIGHTS AVE. BALTO., MD.23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a. CEREBROVASCULAR ACCIDENT

Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

~12 DAYS

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. ATRIAL FIBRILLATION

Due to (or as a consequence of):

-12 DAYS

c. ATHEROSCLEROTIC CARDIOVASCULAR DISEASE SEVERAL YEARS

Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☒ Yes 2 ☐ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical
examiner?
1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify) EXTENDED CARE FACILITY

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending Investigation
6 ☐ Could not be determined28a. Date of Injury
(Month, Day Year)28b. Time of
Injury28c. Injury at
Work?1 ☐ Yes 2 ☐ No28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

MARY JUDELIN MINGUITO, M.D.
Mary Judelin Minguito

29c. License number

AS2441614-22 MAY 26, 1996

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MARY JUDELIN MINGUITO, M.D. - HARBOR HOSPITAL CENTER BALT. MD

31. Date filed (Month, Day, Year)

MAY 29 1996

32. Registrar's Signature

Julia Davidson-Randall
*Julia Davidson-Randall*State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 15868

| | | | | | | | | | | |
|---|--|--|---|--|--|--|--|---|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
William Annand Park | | | | 2. Date of Death
Month May Day 25 Year 1996 | | | | 3. Time of Death
6:20pm | |
| | 4e. Facility Name (If not Institution, give street and number)
Cheasapeake Health Care | | | | 4b. City, Town, or Location of Death
Arnold | | | | 4c. County of Death
Anne Arundel | |
| Funeral
Director | 5. Social Security Number
578-07-2887 | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday)
85 Yrs. | | 8. Date of Birth (Month, Day, Year)
Feb. 11, 1911 | | 9. Birthplace (State or Foreign Country)
Washington DC | |
| | Usual Residence of Decedent | | | | | | | | | |
| To Be Completed by Funeral Director | 10e. State
MD | | 10b. County
Anne Arundel | | 10c. City, Town or Location
Churchton | | | | 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| | 10e. Street and Number
1244 Ellicott Avenue | | | | 10f. Zip Code
20733 | | 10g. Citizen of What Country?
USA | | | |
| | 11. Marital Status
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc.
Specify: White | | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (1-4 or 5+) | | | | 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Owner/Operator | | | 16b. Kind of Business/Industry
Contracting | | |
| | 17. Father's Name (First, Middle, Last)
William Park | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Margaret Ritchie | | | | | |
| To Be Completed by Physician/Medical Examiner | 19e. Informant's Name/Relationship (Type, Print)
Hallie May Park | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1244 Ellicott Ave. Churchton, MD 20733 | | | | | |
| | 20e. Method of Disposition
<input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Metro Crematory | | Date
5/28 | | 20c. Location - City or Town, State
Baltimore, MD | | | |
| | 21. Signature of Funeral Service Licensee
<i>Kimberly S. Rowe</i> | | | | 22. Name and Address of Facility
Hardesty Funeral Home, P.A.
12 Ridgely Ave. Annapolis, MD 21401 | | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
Coronary Heart Failure
Due to (or as a consequence of):
Coronary Artery Disease
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Due to (or as a consequence of):

Due to (or as a consequence of):
 | | | | | | | | | |
| | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | | | | | | | | |
| To Be Completed by Physician/Medical Examiner | 24e. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | | |
| | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | | | |
| | 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | | |
| | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | | | |
| | 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | | | | | | | | |
| To Be Completed by Physician/Medical Examiner | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury et Work?
<input type="checkbox"/> Yes <input type="checkbox"/> No | | 28d. Describe how injury occurred | | | |
| | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| | 29a. Certifier
(Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | | |
| | 29b. Signature and title of certifier
<i>William M. Attending Doctor</i> | | | | 29c. License number
D21684 | | 29d. Date signed (Month, Day, Year)
5-28-96 | | | |
| | 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)
C. V. CYRIAC - M.D. 1600 CRAWFORD GLANBURN RD, MD 21061. | | | | | | | | | |
| State Registrar | 31. Date filed (Month, Day, Year)
MAY 29 1996 | | | | 32. Registrar's Signature
<i>Davidson-Rendall</i> | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 15869

Certificate of Death

Reg. No.

| | | | | | | | | | | |
|---|---|--|---|--|--|--|--|---|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
LINDA DARNELL RIDENOUR | | | | | | 2. Date of Death
Month MAY Day 22 Year 1996 | | 3. Time of Death
10:10 P.M. | |
| | 4a. Facility Name (If not institution, give street and number)
4019 BELLE GROVE ROAD | | | | | | 4b. City, Town, or Location of Death
Baltimore | | 4c. County of Death
ANNE ARUNDEL | |
| Funeral
Director | 5. Social Security Number
unknown | | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday)
38 Yrs. | | 8. Date of Birth (Month, Day, Year)
Nov. 26, 1957 | | 9. Birthplace (State or Foreign Country)
New Jersey | |
| | Usual Residence of Decedent | | | | | | | | | |
| To Be Completed by Funeral Director | 10a. State
Maryland | | 10b. County
Anne Arundel | | 10c. City, Town or Location
Baltimore | | | | 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| | 10e. Street and Number
4019 Belle Grove Road | | | | 10f. Zip Code
21225 | | 10g. Citizen of What Country?
U.S. | | | |
| | 11. Marital Status
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced | | 12. Was Decedent Ever In U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc.
Specify: White | | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 8th College (1-4or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Waitress | | | 16b. Kind of Business/Industry
Restaurant | | |
| | 17. Father's Name (First, Middle, Last)
John Edgar Foard | | | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Catherine Lorraine Bush | | | |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print)
Fannie Sue Turner | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1629 Spruce Street Baltimore, Maryland 21225 | | | | | |
| | 20a. Method of Disposition
<input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Metro Crematory, Inc. | | Date
5/29/96 | | 20c. Location - City or Town, State
Baltimore, Maryland | |
| | 21. Signature of Funeral Service Licensee
<i>[Signature]</i> | | | | 22. Name and Address of Facility
Gonce Funeral Home P.A.
4001 Ritchie Highway Baltimore, Md. 21225 | | | | | |
| | 23a. Part I. Enter the disease, or conditions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. CIRRHOSIS OF THE LIVER
Due to (or as a consequence of):
b. Chronic ALCOHOLISM
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d. | | | | | | | | | |
| | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | | | | | |
| To Be Completed by Physician/Medical Examiner | 24a. Was an autopsy performed?
Partial
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | |
| | 25. Was case referred to medical examiner?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | |
| | 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation
<input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined
<input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | |
| | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| | 29e. Certifier (Check only one)
<input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | |
| State Registrar | 29b. Signature and title of certifier
<i>[Signature]</i> | | | | 29c. License number
O.C.M.E. | | 29d. Date signed (Month, Day, Year)
MAY 23, 1996 | | | |
| | 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)
Maryland P. Kosow MD 111 Penn Street, Baltimore, Maryland 21201 | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
MAY 29 1996 | | | | | | | | | | |

1. The first part of the document discusses the importance of maintaining accurate records of all transactions. It emphasizes that proper record-keeping is essential for the transparency and accountability of the organization. This section also outlines the various methods used to collect and analyze data, ensuring that the information is reliable and up-to-date.

2. The second part of the document focuses on the implementation of these practices. It details the steps involved in setting up a robust system for data collection and analysis. This includes identifying the key areas of focus, selecting appropriate tools and techniques, and ensuring that all staff are trained and equipped to handle the data effectively. The goal is to create a seamless process that allows for the efficient management of information.

3. The third part of the document addresses the challenges faced during the implementation phase. It acknowledges that there may be resistance to change or a lack of resources, but it provides strategies to overcome these obstacles. By fostering a culture of collaboration and providing necessary support, the organization can successfully integrate these practices into its daily operations.

4. The final part of the document summarizes the key findings and conclusions. It reiterates the importance of continuous improvement and the need to regularly review and update the system. The document concludes by expressing confidence in the organization's ability to achieve its goals through the effective use of data and proper record-keeping.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 15870

Certificate of Death

Reg. No.

| | | | | | | | | | | |
|--|---|--|--|--------------------------|--|--|---|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
WILLIAM H. STOVALL SR. | | | | | | 2. Date of Death
Month Day Year
MAY 22 1996 | | 3. Time of Death
6:18 PM | |
| | 4e. Facility Name (If not institution, give street and number)
2809 WINDSOR AVE | | | | | | 4b. City, Town, or Location of Death
BALTO | | 4c. County of Death
N/A | |
| Funeral
Director | 5. Social Security Number
216-12-0183 | | 6. Sex
1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 7. Age (In yrs. last birthday)
77 Yrs. | | 8. Date of Birth (Month, Day, Year)
5-9-19 | | 9. Birthplace (State or Foreign Country)
GA | |
| | Usual Residence of Decedent | | | | | | | | | |
| To Be Completed by Funeral Director | 10a. State
MD | | 10b. County
NA | | 10c. City, Town or Location
BALTIMORE | | | | 10d. Inside City Limits
1 <input checked="" type="checkbox"/> Yea 2 <input type="checkbox"/> No | |
| | 10e. Street and Number
2809 WINDSOR AVENUE | | | | 10f. Zip Code
21216 | | 10g. Citizen of What Country?
USA | | | |
| | 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever In U.S. Armed Forces?
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No
If Yes, Give Year or Dates: thru 11/7/45 | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc.
Specify: BLACK | | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12th College (1-4 or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
CLERK | | | 16b. Kind of Business/Industry
POSTAL SERVICE | | |
| | 17. Father's Name (First, Middle, Last)
JAMES STOVALL | | | | | | 18. Mother's Name (First, Middle, Maiden Surname)
LETTIE JONES | | | |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print)
ROSALIND SETH-DAUGHTER | | | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
3304 WINDSOR BLVD BALTO., MD 21207 | | | |
| | 20a. Method of Disposition
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
GARRISON FOREST VA | | Date
5/29/96 | | 20c. Location - City or Town, State
OWINGS MILLS, MD | | | |
| | 21. Signature of Funeral Service Licensee
<i>Shannon Stokes</i> | | | | | | 22. Name and Address of Facility
MARCH F/H-WEST 4300 WABASH AVE | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | | | |
| | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | | | | | | | |
| 23c. Immediate Cause (Final disease or condition resulting in death)
Coronary artery disease
Due to (or as a consequence of): | | | | | | | | | | |
| 23d. Diabetic mellitus
Due to (or as a consequence of): | | | | | | | | | | |
| 23e. Peripheral vascular disease
Due to (or as a consequence of): | | | | | | | | | | |
| 23f. Cardiopulmonary arrest
Due to (or as a consequence of): | | | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | | | |
| 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yea 2 <input checked="" type="checkbox"/> No | | | | | | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yea 2 <input type="checkbox"/> No | | | | | | | | | | |
| 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | | | | |
| 26. Place of Death (Check only one)
Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | | | | |
| 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide
5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how Injury occurred | | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | |
| 29a. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | |
| 29b. Signature and title of certifier
<i>[Signature]</i> | | | | | | 29c. License number
D30115 | | 29d. Date signed (Month, Day, Year)
5/29/96 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
T. Ohiokpehai, MD 2600 Liberty Hgts Ave Bkth, MD 21215 | | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
MAY 29 1996 | | | | | | | | | | |
| 32. Registrar's Signature
<i>[Signature]</i> | | | | | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

6

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 15871

Certificate of Death

Reg. No.

| | | | | | | | | |
|---|--|---|--|--|---|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
ELEANORE A. SAY | | | | 2. Date of Death
Month MAY Day 25 Year 1996 | | 3. Time of Death
11.58PM | |
| | 4a. Facility Name (If not institution, give street and number)
4705 Glenarm Ave. | | | | 4b. City, Town, or Location of Death
Baltimore | | 4c. County of Death
N/A | |
| Funeral
Director | 5. Social Security Number
219-22-4276 | | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday)
68 Yrs. | | 8. Date of Birth (Month, Day, Year)
April 22, 1928 | |
| | 9. Birthplace (State or Foreign Country)
Maryland | | 10a. State
Md. | | 10b. County
N/A | | 10c. City, Town or Location
Baltimore | |
| 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 10e. Street and Number
4705 Glenarm Ave. | | 10f. Zip Code
21206 | | 10g. Citizen of What Country?
U.S.A. | | |
| 11. Marital Status
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: White | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12th College (1-4or 5+) N/A | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Secretary | | 16b. Kind of Business/Industry
Attorney | | | | |
| 17. Father's Name (First, Middle, Last)
Martin Gnacyk | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Lena Konski | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
Mr. Melvin J. Say | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
4705 Glenarm Ave. Baltimore, Md. 21206 | | | | |
| 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Gardens Of Faith Cem. | | 20c. Location - City or Town, State
Baltimore, Md. | | 20d. Date
5/29 | | |
| 21. Signature of Funeral Service Licensee
 | | 22. Name and Address of Facility
Hartley Miller Funeral Home
7527 Harford Rd. Baltimore, Md. 21234 | | | | | | |
| 23e. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | | |
| Immediate Cause (Final disease or condition resulting in death) | | a. Uterine Cancer
Due to (or as a consequence of): | | | | Approximate Interval Between Onset and Death
2 years | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | b. Due to (or as a consequence of): | | | | | | |
| | | c. Due to (or as a consequence of): | | | | | | |
| | | d. Due to (or as a consequence of): | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | |
| | | | | | | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| | | 28d. Describe how Injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | |
| 29b. Signature and title of certifier
 | | 29c. License number
0309 29 | | 29d. Date signed (Month, Day, Year)
5/28/96 | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
PAUL CELANO, MD 6569 N. Charles St, Baltimore MD 21204 | | | | | | | | |
| 31. Date filed (Month, Day, Year)
MAY 29 1996 | | 32. Registrar's Signature
 | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

31

RECEIVED
JAN 10 1964

96 15872

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|---|--|---|--|---|---|
| 1. DECEASED'S NAME (First, Middle, Last)
GEORGE J. SCHAEFFER | | | | 2. DATE OF DEATH
MONTH MAY DAY 25 YEAR 1996 | | 3. TIME OF DEATH
4:10 P. | |
| 4. SOCIAL SECURITY NUMBER
216 12 9268 | | 5. SEX
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
77 YRS. | | 7. DATE OF BIRTH (Month, Day, Year)
Feb. 22, 1919 | |
| 9a. FACILITY NAME (If not institution, give street and number)
Maryland Manor Nursing Home | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
Glen Burnie | | 9c. COUNTY OF DEATH
Anne Arundel | |
| RESIDENCE OF DECEASED | | | | | | | |
| 10a. STATE
Maryland | | 10b. COUNTY
Anne Arundel | | 10c. CITY, TOWN OR LOCATION
Glen Burnie | | 10d. INSIDE CITY LIMITS?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 10e. STREET AND NUMBER
7575 E. Howard Road | | | | 10f. ZIP CODE
21060 | | 10g. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 11. MARITAL STATUS
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEASED EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO
IF YES, GIVE WAR OR DATES
World War II | | 13. WAS DECEASED OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify:
White | |
| 15. DECEASED'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12) 6th
College (1-4 or 5+) Inspector | | 16a. DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
Inspector | | 16b. KIND OF BUSINESS/INDUSTRY
Revere Copper & Brass | | | |
| 17. FATHER'S NAME (First, Middle, Last)
Adolph Sefcik | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Marie Dobru | | | |
| 19a. INFORMANT'S NAME (Type/Print)
Mary K. Schaeffer | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
310 Gloucester Drive Glen Burnie, Maryland 21061 | | | |
| 20a. METHOD OF DISPOSITION
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
Cedar Hill Cemetery | | 20c. DATE
5/29 | | 20d. LOCATION — City or Town, State
Baltimore, Maryland | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
<i>Richard Gonce</i> | | | | 22. NAME AND ADDRESS OF FACILITY
George J. Gonce Funeral Home P.A.
4001 Ritchie Hwy. Baltimore, Md. 21225 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
IMMEDIATE CAUSE (Final disease or condition resulting in death) → CORONARY ARTERY DISEASE 8 YEARS
DUE TO (OR AS A CONSEQUENCE OF):
ARTERIO-SCLEROTIC CARDIOVASCULAR DISEASE 8 YEARS
DUE TO (OR AS A CONSEQUENCE OF):
CEREBROVASCULAR THROMBOSIS 5 YEARS
DUE TO (OR AS A CONSEQUENCE OF):
CONGESTIVE HEART FAILURE 1 MONTH
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST | | | | | | | Approximate Interval Between Onset and Death |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
ALZHEIMER'S DISEASE | | | | | | | 24e. WAS AN AUTOPSY PERFORMED?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| 24d. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
<input type="checkbox"/> YES <input type="checkbox"/> NO | | | | | | | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA <input checked="" type="checkbox"/> OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation
<input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined
<input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M | | 28c. INJURY AT WORK?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| | | 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. CERTIFIER (Check only one)
<input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
<i>Harjit Singh M.D.</i> ATTENDING PHYSICIAN | | | | 29c. LICENSE NUMBER
D/4160 | | 29d. DATE SIGNED (Month, Day, Year)
MAY 25, 1996 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type/Print)
HARJIT SINGH M.D., 5410-A RITCHIE HIGHWAY, BALTIMORE, MARYLAND - 21225 | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
MAY 29 1996 | | 32. REGISTRAR'S SIGNATURE
<i>Julia Davidson</i> | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0026

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 96 15873

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

RANDOLPH SCOTT

2. Date of Death

Month
MAYDay
21Year
1996

3. Time of Death

6:25 PM

4a. Facility Name (If not institution, give street and number)

JOHNS HOPKINS HOSPITAL

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

BALTIMORE

Funeral
Director

5. Social Security Number

214-54-3098

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

45

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Na

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

718 N. Milton Avenue

10f. Zip Code

21205

10g. Citizen of What Country?

USA

11. Marital Status

1 ☒ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever In U.S. Armed Forces?

1 ☒ Yes 2 ☐ No
If Yes, Give Year or Dates:

1975

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Secretary

16b. Kind of Business/Industry

Department Human resources Services

17. Father's Name (First, Middle, Last)

Alonzo Scott

18. Mother's Name (First, Middle, Maiden Surname)

Ethel Perry

19a. Informant's Name/Relationship (Type, Print)

Vanessa Scott Sister

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2515 Ashland Ave. Balto. Md. 21205

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Garrison Forest Vet. 5/28/96 Owings Mills, Md.

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

SUE Howelf

22. Name and Address of Facility

UNITY FUNERAL HOME 108 W. NORTH AVE.
614 W. North Ave. Balto. md. 21201

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. aspiration pneumonia
Due to (or as a consequence of):

Approximate Interval Between Onset and Death

one day

Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. seizure
Due to (or as a consequence of):

two days

c. acquired immune deficiency syndrome
Due to (or as a consequence of):

nine years

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Gordon K. Leung MD

29c. License number

N12596

29d. Date signed (Month, Day, Year)

May 21, 1996

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

GORDON LEUNG, TOWER 110, JOHNS HOPKINS HOSPITAL 600 WOLFE ST, BALTIMORE, MD 21287

31. Date filed (Month, Day, Year)

MAY 29 1996

32. Registrar's Signature

J. Davidson-Randall

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

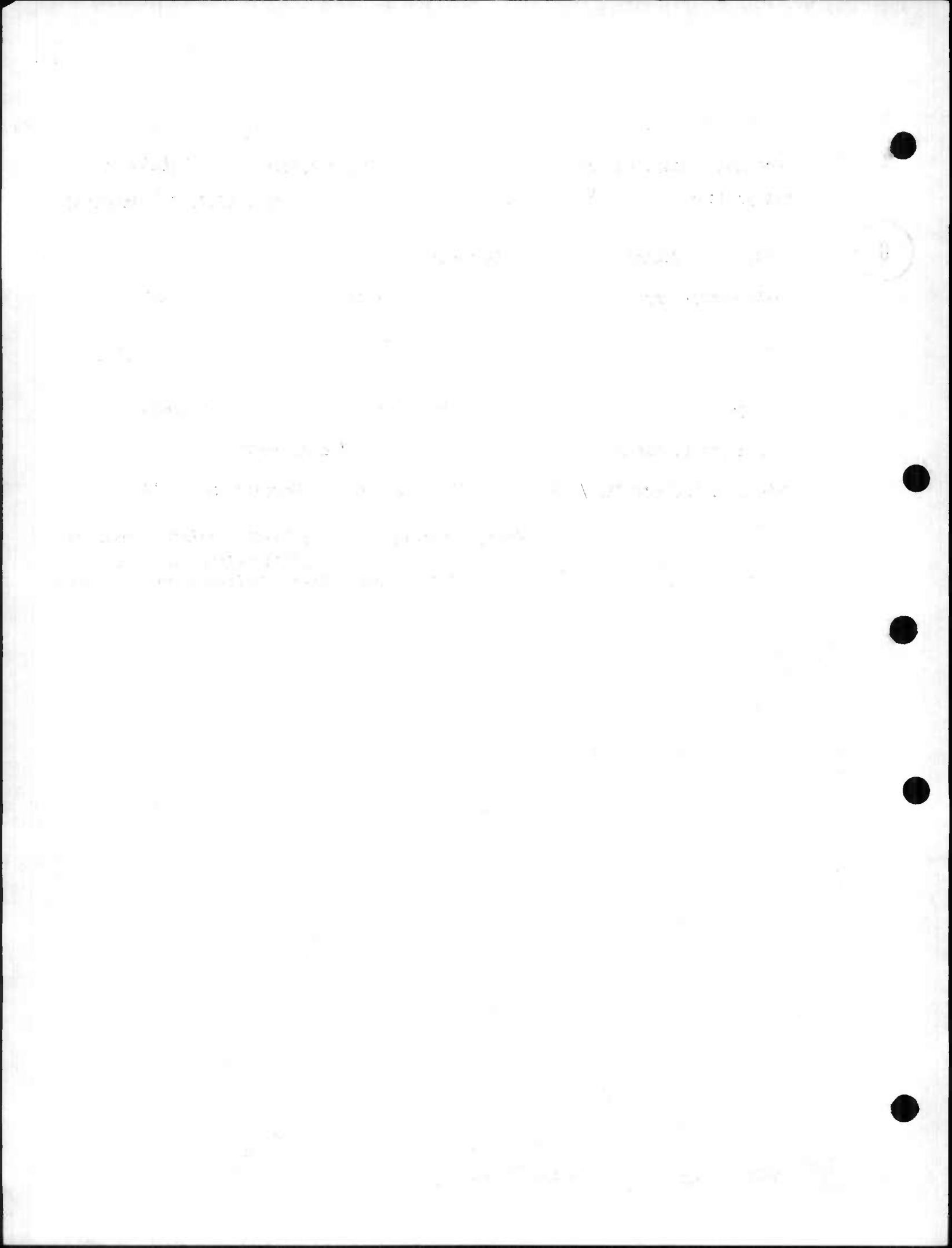
State of Maryland / Department of Health and Mental Hygiene

96 15874

Certificate of Death

Reg. No.

| | | | | | | | | |
|---|--|--|--|--|--|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
EDITH M. STUBBILL | | | | 2. Date of Death
Month MAY Day 23 Year 1996 | | 3. Time of Death
1:10 PM | |
| | 4a. Facility Name (If not institution, give street and number)
Northwest Hosp. Center | | | | 4b. City, Town, or Location of Death
Randallstown | | 4c. County of Death
Baltimore | |
| Funeral
Director | 5. Social Security Number
216-62-4521 | | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday)
76 Yrs. | | 8. Date of Birth (Month, Day, Year)
Apr. 26, 1920 | |
| | 9. Birthplace (State or Foreign Country)
Maryland | | 10a. State
Md. | | 10b. County
Carroll | | 10c. City, Town or Location
Finksburg | |
| To Be Completed by Funeral Director | 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 10e. Street and Number
3233 Murray Road | | 10f. Zip Code
21048 | | 10g. Citizen of What Country?
USA | |
| | 11. Marital Status
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: White | |
| To Be Completed by Physician/Medical Examiner | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (1-4 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Homemaker | | 16b. Kind of Business/Industry
Own home | | 17. Father's Name (First, Middle, Last)
Charles V. Carey | |
| | 18. Mother's Name (First, Middle, Maiden Surname)
Ida M. Henry | | 19a. Informant's Name/Relationship (Type, Print)
Robert F. Talbert Jr. / Son | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
4704 Butler Road Glyndon, Md. 21071 | | 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | |
| To Be Completed by Physician/Medical Examiner | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Grace Cemetery | | 20c. Date
5-25-96 | | 20d. Location - City or Town, State
Reisterstown, Md. | | 21. Signature of Funeral Service licensee
Eline Funeral Home | |
| | 22. Name and Address of Facility
11824 Reisterstown Road Reisterstown, Md. 21136 | | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
COPD | | 23b. Approximate interval between Onset and Death
5 years | | 23c. Did tobacco use contribute to the cause of death?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | |
| To Be Completed by Physician/Medical Examiner | 23d. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 23e. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 25. Place of Death (Check only one)
Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | |
| | 26. Manner of Death
<input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | 26a. Date of Injury (Month, Day, Year) | | 26b. Time of Injury
M | | 26c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| To Be Completed by Physician/Medical Examiner | 26d. Describe how injury occurred | | 26e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 26f. Location (Street and Number or Rural Route Number, City or Town, State) | | 27. Certifier (Check only one)
<input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | |
| | 27a. Signature and title of certifier
A. J. IMPERIAL, Jr. | | 27b. License number
D44505 | | 27c. Date signed (Month, Day, Year)
MAY 23, 1996 | | 28. Name and address of person who completed cause of death (Item 23a) (Type, Print)
A. J. IMPERIAL, Jr. - NWHC | |
| To Be Completed by Physician/Medical Examiner | 28a. Date filed (Month, Day, Year)
MAY 29 1996 | | 28b. Registrar's Signature
Adison-Randall | | 28c. Date of Death (Month, Day, Year)
MAY 23, 1996 | | 28d. Time of Death
1:10 PM | |
| | 28e. Place of Death (Check only one)
Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | 28f. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28g. Describe how injury occurred | | 28h. Location (Street and Number or Rural Route Number, City or Town, State) | |



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 15875

Certificate of Death

Reg. No.

| | | | | | | | | |
|--|---|---|--------------------------|--|---|---|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
SYLVESTER SAMUEL SNIDER | | | | 2. Date of Death
Month Day Year
MAY 25, 1996 | | 3. Time of Death
2236 PM | |
| | 4a. Facility Name (If not institution, give street and number)
JOHNS HOPKINS HOSPITAL | | | | 4b. City, Town, or Location of Death
BALTIMORE | | 4c. County of Death
N/A | |
| Funeral
Director | 5. Social Security Number
218-86-4929 | | 6. Sex
1 M 2 F | | 7. Age (In yrs. last birthday)
26 Yrs. | | 8. Date of Birth (Month, Day, Year)
JAN 26, 1970 | |
| | 9. Birthplace (State or Foreign Country)
MD | | 10a. State
MD | | 10b. County
N/A | | 10c. City, Town or Location
BALTO | |
| 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 10e. Street and Number
3559 ELMLEY AVE | | 10f. Zip Code
21213 | | 10g. Citizen of What Country?
U.S.A. | | |
| 11. Marital Status
<input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever In U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: BLACK | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 10th
College (1-4 or 5+) N/A | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
BUS BOY | | 16b. Kind of Business/Industry
RESTAURANT | | | | |
| 17. Father's Name (First, Middle, Last)
SYLVESTER TOLES | | | | 18. Mother's Name (First, Middle, Maiden Surname)
GARNATOR SNIDER | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
GARNATOR SNIDER | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
2339 ELMLEY AVE BALTO, MD 21213 | | | | |
| 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
DULANEY VALLEY MEM | | 20c. Location - City or Town, State
BALTO, MD | | 20d. Date
JUNE 1 1996 | | |
| 21. Signature of Funeral Service Licensee
 | | | | 22. Name and Address of Facility
betts funeral home
1129 N. CAROLINE ST BALTO, MD 21213 | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
e. GUNSHOT WOUND OF CHEST
Due to (or as a consequence of):

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of): | | | | | | | | |
| 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | | | | |
| 24a. Was an autopsy performed?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | | |
| 25. Was case referred to medical examiner?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | | |
| 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | | |
| 27. Manner of Death
<input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide
<input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year)
05/25/96 | | 28b. Time of Injury
unk PM | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 28d. Describe how injury occurred
SUBJECT SHOT | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
ALLEY | | 28f. Location (Street and Number or Rural Route Number, City or Town, State)
200 blk. collington BALTIMORE, MD. | | | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Certifying Physician: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | |
| 29b. Signature and title of certifier
 | | | | 29c. License number
O.C.M.E. | | 29d. Date signed (Month, Day, Year)
MAY 26, 1996 | | |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)
MARGARITA KORELI, M.D., 111 PENN Street, Baltimore, Maryland 21201 | | | | | | | | |
| 31. Date filed (Month, Day, Year)
MAY 29 1996 | | | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 15876

Certificate of Death

Reg. No.

| | | | | | | | | | |
|---|--|--|--|--------------------------------------|---|---|--|---|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Madeline Sophia Stacey | | | | 2. Date of Death
Month May Day 25 Year 1996 | | 3. Time of Death
3:15 P | | |
| | 4a. Facility Name (If not institution, give street and number)
North Arundel Nursing Center | | | | 4b. City, Town, or Location of Death
Glen Burnie | | 4c. County of Death
Anne Arundel | | |
| Funeral
Director | 5. Social Security Number
079 26 6298 | | 6. Sex
1 M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday)
88 Yrs. | | 8. Date of Birth (Month, Day, Year)
Feb 26 1908 | | |
| | 9. Birthplace (State or Foreign Country)
Pa. | | 10a. State
Md | | 10b. County
Anne Arundel | | 10c. City, Town or Location
Odenton | | |
| To Be Completed by Funeral Director | Usual Residence of Decedent | | | | 10d. Inside City Limits
1 Yes 2 <input checked="" type="checkbox"/> No | | | | |
| | 10e. Street and Number
510 JoAnn Drive | | | | 10f. Zip Code
21113 | | 10g. Citizen of What Country?
USA | | |
| | 11. Marital Status
1 Never Married 2 Married
3 Widowed 4 Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
White | | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12)
7th | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Housewife | | 16b. Kind of Business/Industry
Own Home | | | | |
| | 17. Father's Name (First, Middle, Last)
Charles Albert | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Ella McGee | | | | |
| | 19a. Informant's Name/Relationship (Type, Print)
Roma Ferguson | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
510 JoAnn Drive, Odenton, Md 21113 | | | | |
| | 20a. Method of Disposition
1 Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Pine Lawn National | | Date
5/29/96 | | 20c. Location - City or Town, State
N.Y. | | |
| | 21. Signature of Funeral Service Licensee
Kimberly S. Rowe | | 22. Name and Address of Facility
Hardesty Funeral Home, P.A., 12 Ridgely Ave., Annapolis, Md 21401 | | | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. Sepsis
Due to (or as a consequence of):
b. Sacral Decubitus
Due to (or as a consequence of):
c. Multi-infarct Dementia
Due to (or as a consequence of):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last | | | | | | | Approximate Interval Between Onset and Death
5/96
4/96
11/91 | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Neurogenic Bladder
Indwelling Foley Catheter | | | | | | | 23b. Did tobacco use contribute to the cause of death?
1 Yes 2 No 3 Probably 4 Unknown | |
| 24a. Was an autopsy performed?
1 Yes 2 <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death?
1 Yes 2 No | | | | | | | |
| 25. Was case referred to medical examiner?
1 Yes 2 <input checked="" type="checkbox"/> No | | 28. Place of Death (Check only one)
Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 Residence 8 Other (Specify) | | | | | | | |
| 27. Manner of Death
1 Natural 5 Pending Investigation
2 Accident 6 Could not be determined
3 Suicide 4 Homicide | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
1 Yes 2 No | | 28d. Describe how Injury occurred | |
| 29a. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier
George Hebard MD | | 29c. License number
D31244 | | 29d. Date signed (Month, Day, Year)
5-28-96 | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
George Hebard MD 1600 Chas. T. Jones, Suite 280 | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
MAY 29 1996 | | 32. Registrar's Signature
George Hebard MD | | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

State Registrar

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State of Maryland / Department of Health and Mental Hygiene

96 15877

Certificate of Death

Reg. No.

| | | | | | | | | | |
|---|--|--|---|--|--|--|---|--|-----------------------------------|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
CLYDE Merryman TENNYSON, Jr. | | | | 2. Date of Death
Month MAY 21 , 1996 Year | | 3. Time of Death
9:15 A.M. | | |
| | 4a. Facility Name (If not institution, give street and number)
THE JOHNS HOPKINS HOSPITAL | | | | 4b. City, Town, or Location of Death
BALTIMORE CITY | | 4c. County of Death
Baltimore | | |
| Funeral
Director | 5. Social Security Number
213-05-6375 | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (in yrs. last birthday)
75 Yrs. | | 8. Date of Birth (Month, Day, Year)
Dec. 20, 1920 | | |
| | 9. Birthplace (State or Foreign Country)
Maryland | | 10a. State
Pennsylvania | | 10b. County
York Co. | | 10c. City, Town or Location
Cross Roads | | |
| To Be Completed by Funeral Director | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 10e. Street and Number
7056 Church Road | | 10f. Zip Code
17322 | | 10g. Citizen of What Country?
USA | | |
| | 11. Marital Status
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
If Yes, Give Year or Dates: 1944 to 1946 | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: White | | |
| To Be Completed by Physician/Medical Examiner | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (1-4or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Office Manager | | 16b. Kind of Business/Industry
Steel Manufacturing | | | | |
| | 17. Father's Name (First, Middle, Last)
Clyde Merryman Tennyson, Sr. | | | | 16. Mother's Name (First, Middle, Maiden Surname)
Mamie Eva Norwood | | | | |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print)
Bernice W. Tennyson/Wife | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
7056 Church Road, Cross Roads, Pa. 17322 | | | | |
| | 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Round Hill Cemetery | | Data
5/25/96 | | 20c. Location - City or Town, State
Cross Roads, Pa. 17322 | | |
| To Be Completed by Physician/Medical Examiner | 21. Signature of Funeral Service Licensee
 | | | | 22. Name and Address of Facility
J.J. Hartenstein Mortuary, Inc.
19 S. Main St., Stewartstown, Pa. 17363 | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. Aspiration
Due to (or as a consequence of):
b. Sepsis
Due to (or as a consequence of):
c. Cerebral Vascular accident
Due to (or as a consequence of):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | Approximate Interval Between Onset and Death
24 hours.
24 hours.
one month. | |
| To Be Completed by Physician/Medical Examiner | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Binswanger's disease, benign prostatic hypertrophy
coronary artery stenosis | | | | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | |
| | 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| To Be Completed by Physician/Medical Examiner | 26. Place of Death (Check only one)
Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No | |
| | 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation
<input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined
<input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day Year)
May 21, 1996 | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred |
| To Be Completed by Physician/Medical Examiner | 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier
 | | 29c. License number
NZ558 | | 29d. Date signed (Month, Day, Year)
May 21, 1996 | | |
| | 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)
Karl Hsu MD, Tower 110, Johns Hopkins Hospital Baltimore MD | | | | | | | | |
| State Registrar | 31. Date filed (Month, Day, Year)
MAY 29 1996 | | | | 32. Registrar's Signature
 | | | | |

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 15878

Certificate of Death

Reg. No.

| | | | | | | | | |
|---|--|---|---|--|---|--|-----------------------------|---|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
JOSEPH JOHN THOMAS | | | | 2. Date of Death
Month Day Year
MAY 25 1996 | | 3. Time of Death
5:00 am | |
| | 4a. Facility Name (If not Institution, give street and number)
2529 Ashton Street | | | | 4b. City, Town, or Location of Death
Baltimore | | 4c. County of Death | |
| Funeral
Director | 5. Social Security Number
199-12-4892 | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)
71 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth (Month, Day, Year)
sep 22, 1924 | | 9. Birthplace (State or Foreign Country)
Pennsylvania |
| | Usual Residence of Decedent | | | | | | | |
| 10a. State
MD | | 10b. County | | 10c. City, Town or Location
Baltimore | | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | |
| 10a. Street and Number
2529 Ashton Street | | | | 10f. Zip Code
21223 | | 10g. Citizen of What Country?
USA | | |
| 11. Marital Status
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: WWII | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: white | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) College (1-4 or 5+) 2 | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Supervisor | | 16b. Kind of Business/Industry
Sealtest Foods | | |
| 17. Father's Name (First, Middle, Last)
Charles Thomas | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Rose Richards | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
Mr. Dan Thomas, Son | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
5410 Council Street, Baltimore, MD 21227 | | | | |
| 20a. Method of Disposition
<input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Arlington National Cem. | | Date
6/3/96 | | 20c. Location - City or Town, State
Arlington, VA | | |
| 21. Signature of Funeral Service Licensee
 | | | | 22. Name and Address of Facility
Gary L. Kaufman Funeral Home of Elkridge, Inc.
5695 Main Street, Elkridge, MD 21227 | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. CHRONIC BRONCHITIS + EMPHYSEMA
Due to (or as a consequence of):
b. PULMONARY HYPERTENSION
Due to (or as a consequence of):
c. SMOKING CIGARETTES
Due to (or as a consequence of):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | | Approximate Interval Between Onset and Death
YEARS
11 |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
MALIGNANT NEOPLASM LUNG - IN REMISSION | | | | | | 23b. Did tobacco use contribute to the cause of death?
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | |
| | | | | | | 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | |
| | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | |
| 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death
1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation
2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined
3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28d. Describe how injury occurred | | | | |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | |
| 29a. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | |
| 29b. Signature and title of certifier
Jay Gerstenblith, M.D. | | | | 29c. License number
D 20724 | | 29d. Date signed (Month, Day, Year)
MAY, 25, 1996 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
JAY GERSTENBLITH, M.D. 3455 WILKENS AVE, BALTO, MD 21229 | | | | | | | | |
| 31. Date filed (Month, Day, Year)
MAY 29 1996 | | 32. Registrar's Signature
 | | | | | | |

Baltimore, Maryland 21215-0020

permt. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

6 + 1

Home of Mr.
dges, MD 21221

Charles J

Mr. Dan Tho

x

5

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State of Maryland / Department of Health and Mental Hygiene

96 15879

ITEM#4a film g735 /29/96ag perFH Certificate of Death

Reg. No.

Physician
/Medical
ExaminerFuneral
Director

1. Decedent's Name (First, Middle, Last)

Louis Joseph Tauber

2. Date of Death

May

Day Year
22, 1996

3. Time of Death

6:30 A. M.

4a. Facility Name (If not institution, give street and number)

822 N. Linwood Avenue

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

5. Social Security Number

216-10-1781

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

91

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

June 7, 1904

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State
Maryland10b. County
N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

822 N. Linwood Avenue

10f. Zip Code

21205

10g. Citizen of What Country?

U. S. A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Physician/Medical Examiner

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
7th Grade

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Salesman/Driver

16b. Kind of Business/Industry

Brewery

17. Father's Name (First, Middle, Last)

Frank Tauber

18. Mother's Name (First, Middle, Maiden Summa)

Mary Wegarntar

19a. Informant's Name/Relationship (Type, Print)

Louis J. Tauber Jr. (Son)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3301 Batavia Avenue, Baltimore, Maryland 21214

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Gardens of Faith

Date

5/24/ 96

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Schimunek Funeral Home Inc.
3331 Brehms Lane, Baltimore, Maryland 21213

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. ASCVD ? myo cardial infarction

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. D mellitus

Due to (or as a consequence of):

c. Hypertension

Due to (or as a consequence of):

d. Arteriosclerosis

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☒ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Preliminary Examiner

29c. License number

D14826

29d. Date signed (Month, Day, Year)

5/27/96

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

PRATIMA PROSE Suite 803, 301 St. Paul Place Baltimore MD 21202

31. Date filed (Month, Day, Year)

MAY 29 1996

32. Registrar's Signature

John Anderson-Randall

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-d show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 15880

Certificate of Death

Reg. No.

| | | | | | | | | |
|---|--|---|--|--|---|---|---|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
JESSE T. WINGO | | | | 2. Date of Death
Month Day Year
MAY 14, 1996 | | 3. Time of Death
12:25 P.M. | |
| | 4a. Facility Name (If not institution, give street and number)
NORTH ARUNDEL HOSPITAL | | | | 4b. City, Town, or Location of Death
GLEN BURNIE | | 4c. County of Death
ANNE ARUNDEL | |
| Funeral
Director | 5. Social Security Number
225-10-6495 | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday)
84 Yrs. | | 8. Date of Birth (Month, Day, Year)
Sept 13 1912 | |
| | 9. Birthplace (State or Foreign Country)
Virginia | | 10a. State
MD | | 10b. County
Arlington | | 10c. City, Town or Location
Glen Burnie | |
| 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 10e. Street and Number
6902 Glen Ridge Cr Apt A1 | | 10f. Zip Code
21061 | | 10g. Citizen of What Country?
USA | | |
| 11. Marital Status
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
If Yes, Give Year or Dates: WWII | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: white | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12)
10 | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Truck Driver | | 16b. Kind of Business/Industry
American Excelior | | | | |
| 17. Father's Name (First, Middle, Last)
Charles Wingo | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Unknown | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
Venona F. Davenport | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
6902 Glen Ridge Cr Apt A1 Glen Burnie MD 21061 | | | | |
| 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Crownsville Vet Cem | | 20c. Location - City or Town, State
5-17-96 Crownsville, MD | | | | |
| 21. Signature of Funeral Service Licensee
Thomas A. ... | | 22. Name and Address of Facility
Raymond C. Fink Funeral Home
426 Capin Hwy SW Glen Burnie MD 21061 | | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. RESPIRATORY FAILURE.
Due to (or as a consequence of):
b. PNEUMONIA
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I.
RECTAL BLEEDING
HISTORY OF ABDOMINAL ANEURYSM
HISTORY OF CARDIAC ARRHYTHMIAS | | | | | | | | |
| 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | | | | |
| 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation
<input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined
<input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | 28a. Date of injury (Month, Day Year) | | 28b. Time of injury
M | | 28c. Injury at work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 28a. Place of injury - At home, farm, street, factory, office building, etc. (Specify) | | 28d. Describe how injury occurred | | | | | | |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | |
| 29b. Signature and title of certifier
J. ... M.D. | | 29c. License number
D-22609 | | 29d. Date signed (Month, Day, Year)
5/28/96 | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
RUBEN REIDER, M.D. 7445 FURNACE BRANCH ROAD GLEN BURNIE, MARYLAND 21060 | | | | | | | | |
| 31. Date filed (Month, Day, Year)
MAY 29 1996 | | 32. Registrar's Signature
Julia ... | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

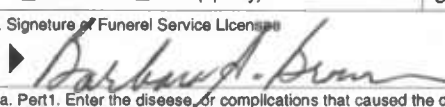
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 15881

Certificate of Death

Reg. No.

| | | | | | | | | | |
|---|--|---|--|---|---|--|---|---|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Nathaniel Watson | | | | 2. Date of Death
Month May Day 23 Year 1996 | | 3. Time of Death
2:45pm | | |
| | 4a. Facility Name (If not institution, give street and number)
Johns Hopkins Bayview | | | | 4b. City, Town, or Location of Death
BALTIMORE CITY | | 4c. County of Death
N/A | | |
| Funeral
Director | 5. Social Security Number
216-42-1600 | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday)
53 Yrs. | | 8. Date of Birth (Month, Day, Year)
Nov. 16 1942 | | |
| | 9. Birthplace (State or Foreign Country)
MARYLAND | | 10. Usual Residence of Decedent
10a. State MARYLAND 10b. County N/A 10c. City, Town or Location BALTIMORE CITY 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 11. Marital Status
<input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: 1966/69 | | |
| To Be Completed by Funeral Director | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: BLACK | | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12th grade College (1-4or 5+) U.S. COAST GUARD | | 16. Kind of Business/Industry
GOVERNMENT | |
| | | 17. Father's Name (First, Middle, Last)
JAMES WATSON | | 18. Mother's Name (First, Middle, Maiden Surname)
LOUISA WATSON | | 19. Informant's Name/Relationship (Type, Print)
Barbara Burley/Sister | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1905 Crosstrails Rd, Baltimore Maryland 21244 | |
| Physician
/Medical
Examiner | | 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
GARRISON FOREST VETERANS | | 20c. Date
5-31-96 | | 20d. Location - City or Town, State
OWINGS MILLS, MARYLAND | |
| | | 21. Signature of Funeral Service Licensee
 | | 22. Name and Address of Facility
WILLIAM C. BROWN COMMUNITY F/H
1206 W. NORTH AVENUE | | 23a. Pertinent disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
metastatic cancer | | Approximate Interval Between Onset and Death
~ 1 yr. | |
| Division of Vital Records, P.O. Box 68760,
Baltimore, Maryland 21215-0020 | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| | | 26. Place of Death (Check only one)
Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | |
| To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 23b-f show any injury or other traumatic event, the Medical Examiner must be notified at once. | | 28d. Describe how Injury occurred | | 28e. Place of Injury - At home, term, street, tectory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | |
| | | 29b. Signature and title of certifier
C. Song, M.D. | | 29c. License number
56014 | | 29d. Date signed (Month, Day, Year)
May 23, 1996 | | 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)
Lijun Song, M.D.
JHBM, 4940 Eastern Ave. Baltimore, MD 21224 | |
| State Registrar | | 31. Date filed (Month, Day, Year)
MAY 29 1996 | | 32. Registrar's Signature
 | | 10 | | | |

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene
Certificate of Death

15882

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Ellsworth Wilson JR.

2. Date of Death

May 22 1996 11:40 am

3. Time of Death

Funeral
Director

4a. Facility Name (If not institution, give street and number)

Sinai Hospital

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

Baltimore

5. Social Security Number

220-36-1579

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

55 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Nov. 16, 1940

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

BALTIMORE

10c. City, Town or Location

BALTIMORE CITY

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

1035 E. NORTHERN PARKWAY

10f. Zip Code

21212

10g. Citizen of What Country?

USA.

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever In U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: BLACK

To Be Completed by Funeral Director

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

11TH GRADE

Collega (1-4or 5+)

Collega (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

TRUCK DRIVER

16b. Kind of Business/Industry

FREIGHT COMPANY

17. Father's Name (First, Middle, Last)

ELLSWORTH

WILSON SR.

18. Mother's Name (First, Middle, Maiden Surname)

DOROTHY

HOWELL

19a. Informant's Name/Relationship (Type, Print)

DORIS WILSON

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1035 E. NORTHERN PARKWAY, BALTO, MD. 21212

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

WOODLAWN CEMETERY 5-29-96 WOODLAWN, MD.

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

JOSEPH H. BROWN JR.

22. Name and Address of Facility

JOSEPH H. BROWN JR. FUNERAL HOME, P.A.
2140 N. FULTON AVE., BALTIMORE, MD. 21217

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, stroke, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Multiple Organ System Failure

Due to (or as a consequence of):

b. Anoxic Encephalopathy

Due to (or as a consequence of):

c. Ventricular Fibrillation Cardiac Arrest

Due to (or as a consequence of):

d. Dilated Cardiomyopathy

Approximate Interval Between Onset and Death

1 week

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and Title of certifier

James Shero MD

29c. License number

MDAS 2402321-JS-003

29d. Date signed (Month, Day, Year)

May 22, 1996

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

James Shero MD, Sinai Hospital, Baltimore MD

31. Date filed (Month, Day, Year)

MAY 29 1996

32. Registrar's Signature

Davidson-Rendell

State
Registrar

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

96 15883

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|---|--|--|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
<u>Carmelita Widley</u> | | | | 2. DATE OF DEATH
MONTH <u>5</u> DAY <u>27</u> YEAR <u>96</u> | | 3. TIME OF DEATH
<u>3:35 AM</u> M | |
| 4. SOCIAL SECURITY NUMBER
<u>577-12-4231</u> | | 5. SEX
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
<u>95</u> YRS. | | 7. DATE OF BIRTH (Month, Day, Year)
<u>01-01-01</u> | |
| 9a. FACILITY NAME (If not institution, give street and number)
<u>Deaton Medical Center</u> | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
<u>Baltimore City</u> | | 9c. COUNTY OF DEATH
<u>NA</u> | |
| 10a. STATE
<u>MD</u> | | | | 10b. COUNTY
<u>NA</u> | | 10c. CITY, TOWN OR LOCATION
<u>Baltimore City</u> | |
| 10d. INSIDE CITY LIMITS?
<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | | | 10e. STREET AND NUMBER
<u>611 S. Charles Street</u> | | | |
| 10f. ZIP CODE
<u>21230</u> | | | | 10g. CITIZEN OF WHAT COUNTRY?
<u>USA</u> | | | |
| 11. MARITAL STATUS
<input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES. | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO Specify: <u>Puerto Rican</u> | | 14. RACE — American Indian, Black, White, etc.
Specify: <u>NA</u> | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12) <u>UNK</u>
College (1-4 or 5+) <u>UNK</u> | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
<u>UNK</u> | | 16b. KIND OF BUSINESS/INDUSTRY
<u>UNK</u> | | | |
| 17. FATHER'S NAME (First, Middle, Last)
<u>UNK</u> | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
<u>UNK</u> | | | |
| 19a. INFORMANT'S NAME (Type/Print)
<u>Gussie Lavelle</u> | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
<u>861 Park Ave Baltimore, MD. 21201</u> | | | |
| 20a. METHOD OF DISPOSITION
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory, or other place)
<u>MT. ZION</u> | | 20c. LOCATION — City or Town, State
<u>5-29-96 Lansdowne, MD.</u> | | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
<u>[Signature]</u> | |
| 22. NAME AND ADDRESS OF FACILITY
<u>Albert P. Wylie Baltimore, MD. 21217</u> | | | | 23. PART I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
IMMEDIATE CAUSE (Final disease or condition resulting in death) → <u>PNEUMONIA</u>
Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
a. DUE TO (OR AS A CONSEQUENCE OF):
b. DUE TO (OR AS A CONSEQUENCE OF):
c. DUE TO (OR AS A CONSEQUENCE OF):
d. DUE TO (OR AS A CONSEQUENCE OF):
Approximate interval between Onset and Death
<u>WEEKS</u> | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
<u>RHEUMATOID ARTHRITIS, DEMENTIA</u> | | | | 24a. WAS AN AUTOPSY PERFORMED?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
<input type="checkbox"/> YES <input type="checkbox"/> NO | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | |
| 26. PLACE OF DEATH (Check only one)
HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA
OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | 27. MANNER OF DEATH
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | | |
| 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M | | 28c. INJURY AT WORK?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one)
<input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | 29b. SIGNATURE AND TITLE OF CERTIFIER
<u>[Signature]</u> | | 29c. LICENSE NUMBER
<u>D31136</u> | |
| 29d. DATE SIGNED (Month, Day, Year)
<u>MAY 28, 1996</u> | | | | 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
<u>Brian C. Wallace MD 611 S. CHARLES ST. BALTIMORE MD 21230</u> | | | |
| 31. DATE FILED (Month, Day, Year)
<u>MAY 29 1996</u> | | | | 32. REGISTRAR'S SIGNATURE
<u>[Signature]</u> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 15884

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

John H. YOUNG, Jr.

2. Date of Death

Month Day Year
May 27, 1996

3. Time of Death

3:03 a.m.

4a. Facility Name (If not Institution, give street and number)

Franklin Square Hospital

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

Baltimore

5. Social Security Number

212-30-2449

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

63

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Month Day Year
May 26, 1933

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Md.

10b. County

Baltimore

10c. City, Town or Location

Baltimore

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

9903 Magleth Rd.

10f. Zip Code

21234

10g. Citizen of What Country?

U.S.A.

11. Marital Status

☐ Navar Married ☒ Married☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

☒ Yes ☐ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

12th

N/A

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Mechanic

16b. Kind of Business/Industry

Elevator Co.

17. Father's Name (First, Middle, Last)

John H. Young

18. Mother's Name (First, Middle, Maiden Surname)

Norma J. Widmaier

19a. Informant's Name/Relationship (Type, Print)

Mrs. Mary M. Young

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

9903 Magleth Rd. Baltimore, Md. 21234

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

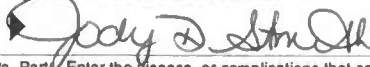
Gardens Of Faith Cemetery 5/31

Data

20c. Location - City or Town, State

Baltimore, Md.

21. Signature of Funeral Service Licensee



22. Name and Address of Facility

Hartley Miller Funeral Home

7527 Harford Rd. Baltimore, Md. 21234

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate
Interval Between
Onset and DeathImmediate Cause (Final
disease or condition
resulting in death)

a. Bronchopneumonia

Due to (or as a consequence of):

1 day

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or Injury
that initiated events
resulting in death) Last

b. Chronic Lymphocytic Leukemia

Due to (or as a consequence of):

12 years

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown

24a. Was an autopsy

performed?

☒ Yes ☐ No

24b. Were autopsy findings

available prior to

completion of cause

of death?

☒ Yes ☐ No

25. Was case referred to medical

examiner?

☐ Yes ☒ No

Hospital:

☒ Inpatient ☐ ER/Outpatient ☐ DOA

26. Place of Death (Check only one)

Other: ☐ Nursing Home ☐ Residence ☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending☐ Accident ☐ Investigation☐ Suicide ☐ Could not be☐ Homicide ☐ determined

28a. Date of Injury

(Month, Day Year)

28b. Time of

injury

28c. Injury at

Work?

☐ Yes ☐ No

28d. Describe how Injury occurred

28a. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier



29c. License number

R01918

29d. Date signed (Month, Day, Year)

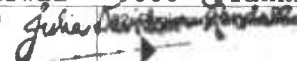
May 27, 1996

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. Anita Aggarwal 9000 Franklin Square Drive Baltimore, Maryland 21237

31. Date filed (Month, Day, Year)

MAY 29 1996



Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

1. The first part of the report is a general
description of the project and its objectives.
2. The second part is a detailed description of the
methodology used in the study.
3. The third part is a description of the results
of the study.

4. The fourth part is a discussion of the
results and their implications.
5. The fifth part is a conclusion and
recommendations for future research.

6. The sixth part is a list of references.
7. The seventh part is an appendix containing
additional data and figures.

96 15885

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|---|--|---|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last)
VINCENT ALFINITO | | | | 2. DATE OF DEATH
MONTH MAY DAY 28 YEAR 1996 | | 3. TIME OF DEATH
2:50 PM | |
| 4. SOCIAL SECURITY NUMBER
218-09 1120 | | 5. SEX
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
77 YRS. | | 7. DATE OF BIRTH (Month, Day, Year)
1918 August 24 | |
| 9a. FACILITY NAME (If not institution, give street and number)
Sandtown Winchester Nursing Home | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
Baltimore | | 9c. COUNTY OF DEATH
n/a | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE
MD | | 10b. COUNTY
n/a | | 10c. CITY, TOWN OR LOCATION
Baltimore | | 10d. INSIDE CITY LIMITS?
<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER
1931 Fleet St. | | | | 10f. ZIP CODE
21231 | | 10g. CITIZEN OF WHAT COUNTRY?
USA | |
| 11. MARITAL STATUS
<input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12) 8th College (1-4 or 5+) | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
Caretaker | | 16b. KIND OF BUSINESS/INDUSTRY
Laundry | |
| 17. FATHER'S NAME (First, Middle, Last)
Vincenzo Alfinito | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Mary Ann Green | | | |
| 19a. INFORMANT'S NAME (Type/Print)
Earl W. Knight | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1101 St. Paul St. suite 2101 BALto, MD 21202 | | | |
| 20a. METHOD OF DISPOSITION
<input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
Metro Crematory | | DATE 5/30 | | 20c. LOCATION — City or Town, State
Catonsville, MD | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
<i>James A. Morton</i> | | | | 22. NAME AND ADDRESS OF FACILITY
James A. Morton & Sons Funeral Home
1701 Laurens St. Balto., MD 21217 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | | a. malignant ventricular arrhythmia
DUE TO (OR AS A CONSEQUENCE OF): | | | | | Approximate interval Between Onset and Death
30 sec |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | b. stroke
DUE TO (OR AS A CONSEQUENCE OF): | | | | | 2 yr |
| | | c. coronary artery disease
DUE TO (OR AS A CONSEQUENCE OF): | | | | | 5 yr |
| | | d. | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
<input type="checkbox"/> YES <input type="checkbox"/> NO | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M | | 28c. INJURY AT WORK?
<input type="checkbox"/> YES <input type="checkbox"/> NO | |
| | | 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28d. DESCRIBE HOW INJURY OCCURRED | | | |
| | | 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| 29a. CERTIFIER (Check only one)
<input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
<i>Dr. Alfinito</i> physician | | | | 29c. LICENSE NUMBER
D29769 | | 29d. DATE SIGNED (Month, Day, Year)
5/28/96 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (Item 27) (Type, Print)
Marcelino D. Albinero MD 516 N. Rolling Rd Balto. | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
MAY 30 1996 | | 32. REGISTRAR'S SIGNATURE
<i>[Signature]</i> | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 5 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 15886

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

MICHAEL

BURIN

2. Date of Death

May 27 1996

3. Time of Death

2:38 am.

4a. Facility Name (If not institution, give street and number)

SAINT JOSEPH MEDICAL CENTER

4b. City, Town, or Location of Death

TOWSON, MD.

4c. County of Death

BALTIMORE

Funeral
Director

5. Social Security Number

197-07-2771

6. Sex

1 ☒ M 2 ☐ F

7. Age (in yrs. last birthday)

80 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

FEB 12, 1916

9. Birthplace (State or Foreign Country)

PENNSYLVANIA

Usual Residence of Decedent

10a. State

MD.

10b. County

Baltimore

10c. City, Town or Location

PARKVILLE

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

3300 WILLOUGHBY Rd.

10f. Zip Code

21234

10g. Citizen of What Country?

USA

11. Marital Status

1 ☒ Navar Married 2 ☐ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever In U.S. Armed Forces?

1 ☒ Yes 2 ☐ No
If Yes, Give Year or Dates: ARMY

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4or 5+)

18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

CUSTODIAN

16b. Kind of Business/Industry

BALTIMORE Co. Schools

17. Father's Name (First, Middle, Last)

MICHAEL BURIN

18. Mother's Name (First, Middle, Maiden Surname)

ANNA MANSIC

19a. Informant's Name/Relationship (Type, Print)

EUGENE LOZOSKIE / nephew

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

8812 Wolverton Rd. Balto. Md. 21234

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

PARKWOOD Cemetery

Data

MAY 23 1996

20c. Location - City or Town, State

PARKVILLE, Md.

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

EVANS CHAPEL OF MEMORIES
8800 HARFORD Rd. Balto. Md. 21234

23a. Part I. Enter the disease, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. RESPIRATORY FAILURE SECONDARY TO

12 DAYS

Due to (or as a consequence of):

b. CENTRAL NERVOUS SYSTEM

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D 41410

29d. Date signed (Month, Day, Year)

May 27th, 96.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JOGINDER P. MEHTA, M.D. ST. JOSEPH MEDICAL CENTER TOWSON, MD.

31. Date filed (Month, Day, Year)

MAY 30 1996

32. Registrar's Signature

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

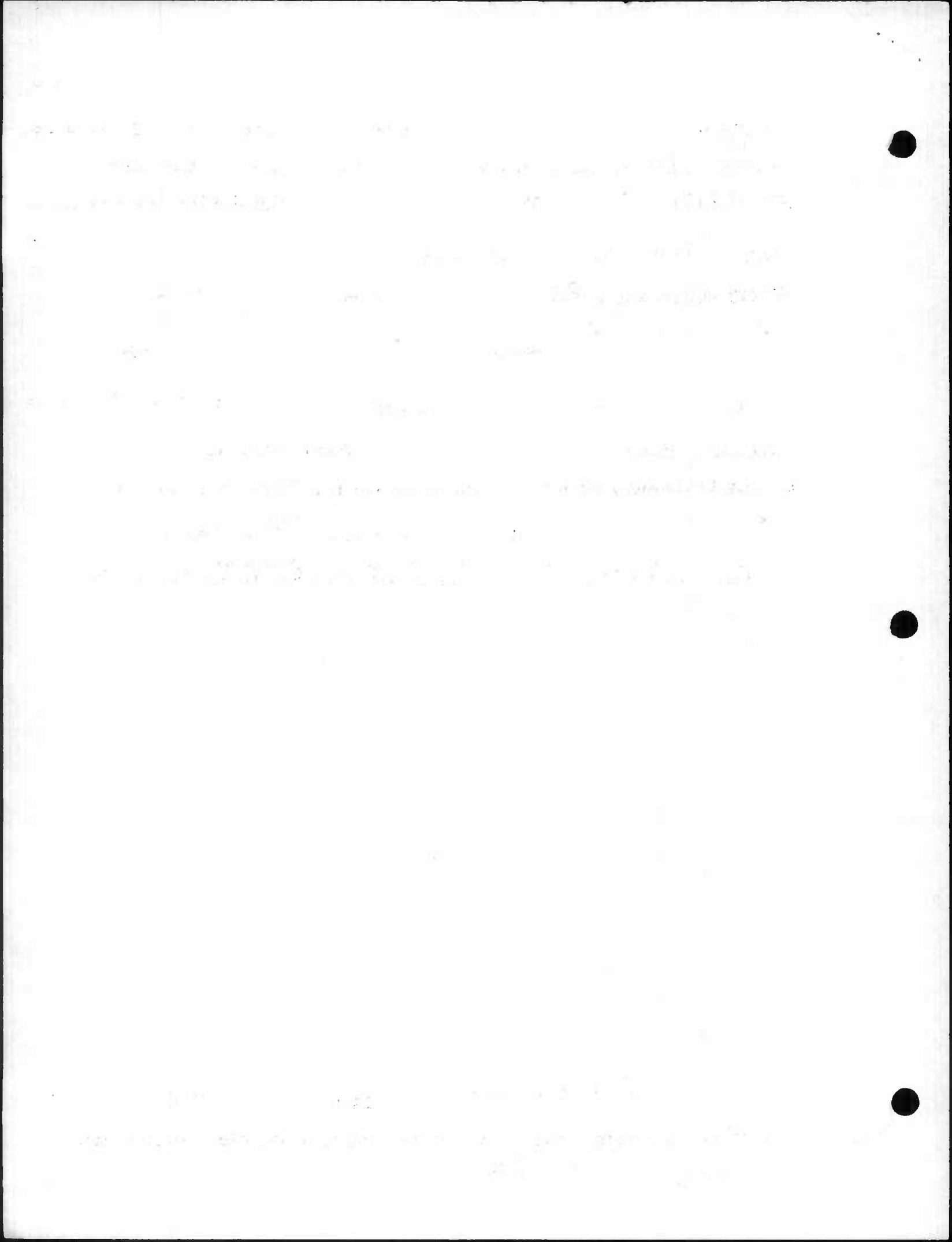
Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar



96 15887

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
Kay K. Black | | | | 2. DATE OF DEATH
MONTH DAY YEAR
May 25, 1996 | | 3. TIME OF DEATH
4:55 PM | |
| 4. SOCIAL SECURITY NUMBER
217-24-4494 | | 5. SEX
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
64 YRS. | | 7. DATE OF BIRTH (Month, Day, Year)
Aug. 25, 1931 | |
| 8. BIRTHPLACE (State or Foreign Country)
Pennsylvania | | | | | | | |
| 9a. FACILITY NAME (If not institution, give street and number)
7810 Harold Road | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
Dundalk | | 9c. COUNTY OF DEATH
Baltimore | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE
Maryland | | 10b. COUNTY
Baltimore | | 10c. CITY, TOWN OR LOCATION
Dundalk | | 10d. INSIDE CITY LIMITS?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 10e. STREET AND NUMBER
7810 Harold Road | | | | 10f. ZIP CODE
21222 | | 10g. CITIZEN OF WHAT COUNTRY?
United States | |
| 11. MARITAL STATUS
1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify: White | |
| 15. DECEDENT'S EDUCATION
(Specify only highest grade completed)
Elementary/Secondary (0-12) 9 Years
College (1-4 or 5+) Inspector | | 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.)
Inspector | | 16b. KIND OF BUSINESS/INDUSTRY
Electric | | | |
| 17. FATHER'S NAME (First, Middle, Last)
Vernon Reno Kapp | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Pauline E. Reese | | | |
| 19a. INFORMANT'S NAME (Type/Print)
Mr. Russell J. Black | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
7810 Harold Road Dundalk, Maryland 21222 | | | |
| 20a. METHOD OF DISPOSITION
1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input checked="" type="checkbox"/> Other (Specify) Entombment | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
Meadowridge Mausoleum 5/29/96 | | 20c. LOCATION — City or Town, State
Dorsey, Maryland | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
Johnny L. Gibbs | | | | 22. NAME AND ADDRESS OF FACILITY
Duda-Ruck Funeral Home of Dundalk, Inc.
7922 Wise Ave. Dundalk, MD 21222 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → Non Hodgkin's Lymphoma | | | | | | | |
| Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA
OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation
2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined
3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 28c. INJURY AT WORK?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. CERTIFIER (Check only one)
<input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
Paul C. Cline, MD | | | | 29c. LICENSE NUMBER
D30927 | | 29d. DATE SIGNED (Month, Day, Year)
5/28/96 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
Paul C. Cline 6569 N. Charles St #205, Baltimore, MD 21204 | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
MAY 30 1996 | | | | 32. REGISTRAR'S SIGNATURE
Julia T. Gordon-Randall | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2 and 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 15888

Physician
/Medical
ExaminerFuneral
Director

1. Decedent's Name (First, Middle, Last)

JOAN ELAINE BOVA

2. Date of Death

MAY 25, 1996

3. Time of Death

8:15 AM

4a. Facility Name (If not institution, give street and number)

8001 REDSTONE RD.

4b. City, Town, or Location of Death

KINGSVILLE

4c. County of Death

BALTIMORE

5. Social Security Number

212-34-5668

6. Sex

1 ☐ M 2 ☒ F

7. Age (in yrs. last birthday)

60 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

DEC. 29 1935

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MD.

10b. County

BALTIMORE

10c. City, Town or Location

KINGSVILLE

10d. inside City Limits

1 ☐ Yea 2 ☒ No

10e. Street and Number

8001 REDSTONE RD.

10f. Zip Code

21087

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

-

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

HOUSEWIFE

16b. Kind of Business/Industry

HOME

17. Father's Name (First, Middle, Last)

MAXIMILLIAN FORTHUBER

18. Mother's Name (First, Middle, Maiden Surname)

CAROLINA I.

19a. Informant's Name/Relationship (Type, Print)

JOSEPH BOVA

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

8001 REDSTONE RD. KINGSVILLE 21087

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

GREENMOUNT CREMATORY

Date

5/27

20c. Location - City or Town, State

BALTIMORE

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

EVANS CHAPEL OF MEMORIES
8800 HARBOR RD. 21234

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Due to (or as a consequence of):

- Metastatic Renal Ca

Approximate interval Between Onset and Death

1 year

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

2 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

M D

29c. License number

D18487

29d. Date signed (Month, Day, Year)

May 26, 1996

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DR. MYO THANT 9101 FRANKLIN SQUARE DRIVE

31. Date filed (Month, Day, Year)

MAY 30 1996

32. Registrar's Signature

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 24a-4 show any injury or other traumatic event, the Medical Examiner must be notified at 5050.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

1. The first part of the paper is devoted to a discussion of the general principles of the theory of the structure of the atom. It is shown that the structure of the atom is determined by the laws of quantum mechanics, and that the laws of quantum mechanics are based on the principle of the conservation of energy.

2. In the second part of the paper, the author discusses the structure of the atom in more detail. He shows that the structure of the atom is determined by the laws of quantum mechanics, and that the laws of quantum mechanics are based on the principle of the conservation of energy.

3. In the third part of the paper, the author discusses the structure of the atom in more detail. He shows that the structure of the atom is determined by the laws of quantum mechanics, and that the laws of quantum mechanics are based on the principle of the conservation of energy.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 15889

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Edith F Bryan

2. Date of Death

Month

Day

Year

MAY 26 1996

3. Time of Death

10:45pm

4a. Facility Name (If not institution, give street and number)

Church Hospital

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

Funeral
Director

5. Social Security Number

213-06-2670

6. Sex

1 ☐ M ☒ F

7. Age (In yrs. last birthday)

87

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)
June 14, 1908

9. Birthplace (State or Foreign Country)

Indiana

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Dundalk

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

215 S. Woodwell Road

10f. Zip Code

21222

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12 Years

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Cashier

16b. Kind of Business/Industry

Parking Garage

17. Father's Name (First, Middle, Last)

Scott Smiley

18. Mother's Name (First, Middle, Maiden Surname)

Elizabeth Bolton

19a. Informant's Name/Relationship (Type, Print)

Frances E. Picci

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

215 S. Woodwell Road Dundalk, Maryland 21222

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Oak Lawn Cemetery 5/30/1996

Date

20c. Location - City or Town, State

Baltimore, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Duda-Ruck Funeral Home of Dundalk, Inc.

7922 Wise Ave. Dundalk, MD 21222

23. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. congestive heart failure

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Left lower lobe pneumonia

Urinary tract infection

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

2 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D18587

29d. Date signed (Month, Day, Year)

MAY 26 1996

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Paul Gormley 100 N. Broadway Balto. Md 21231

31. Date filed (Month, Day, Year)

MAY 30 1996

32. Registrar's Signature

State
Registrar

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020
F
permitted. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 23b-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 15890

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Laura Elizabeth Braden

2. Date of Death

Month Day Year
May 25, 1996

3. Time of Death

11:30 pm

Funeral
Director

4e. Facility Name (If not institution, give street and number)

Johns Hopkins Bayview Medical Center

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

5. Social Security Number

218-76-0201

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

89 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Jan. 8, 1907

9. Birthplace (State or Foreign Country)

Pennsylvania

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Edgemere

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

7734 North Point Road

10f. Zip Code

21219

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

6 Years

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Eli Kerr

18. Mother's Name (First, Middle, Maiden Surname)

Ida Showers

19a. Informant's Name/Relationship (Type, Print)

William Dickey

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1940 Codd Avenue Dundalk, Maryland 21222

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Meadowridge Mem. Ph. Cem.

Date

5/28/96

20c. Location - City or Town, State

Dorsey, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Duda-Ruck Funeral Home of Dundalk, Inc.

7922 Wise Ave. Dundalk, MD 21222

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Cerebral Vascular Accident (stroke)

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

2 days

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

myocardial infarction

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending Investigation
6 ☐ Could not be determined

26a. Date of Injury

(Month, Day, Year)

26b. Time of Injury

M

26c. Injury at Work?

1 ☐ Yes 2 ☐ No

26d. Describe how injury occurred

26a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

26f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

M2568/029880

29d. Date signed (Month, Day, Year)

May 29, 1996

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Donald L. Gilbert

Johns Hopkins Bayview Medical Center
4940 Eastern Avenue, Baltimore, MD 21224

31. Date filed (Month, Day, Year)

MAY 30 1996

32. Registrar's Signature

Baltimore, Maryland 21215-0020
Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or item 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

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... ..
... ..

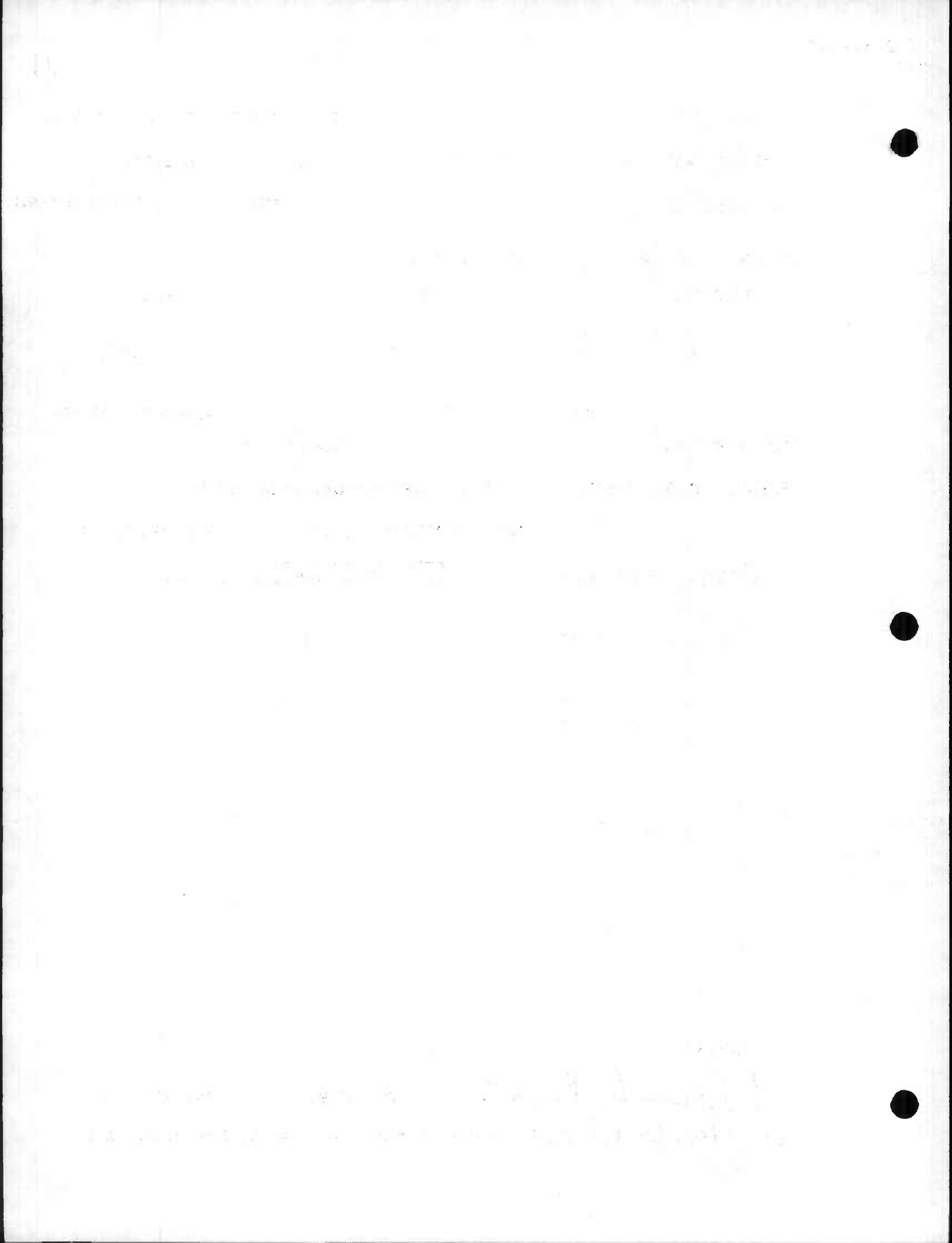
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Certificate of Death

Reg. No.

| | | | | | | | | |
|--|---|--|---|--|---|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
ANNETTE V. BELL | | | | 2. Date of Death
Month Day Year
MAY 24, 1996 | | 3. Time of Death
1:37 PM | |
| | 4a. Facility Name (If not institution, give street and number)
#36 FENWAY SOUTH APT #B | | | | 4b. City, Town, or Location of Death
ESSEX | | 4c. County of Death
BALTIMORE | |
| Funeral
Director | 5. Social Security Number
215-40-8214 | | 6. Sex
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday)
Yrs. 79 | | 8. Date of Birth (Month, Day, Year)
AUGUST 13, 1916 | |
| | 9. Birthplace (State or Foreign Country)
BALTIMORE, MARYLAND | | 10a. State
MARYLAND | | 10b. County
BALTIMORE | | 10c. City, Town or Location
BALTIMORE COUNTY | |
| To Be Completed by Funeral Director | 10d. Inside City Limits
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 10e. Street and Number
36 B FENWAY SOUTH | | 10f. Zip Code
21221 | | 10g. Citizen of What Country?
U.S.A. | |
| | 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No)
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: WHITE | |
| To Be Completed by Physician/Medical Examiner | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (1-4 or 5+) N/A | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
HOMEMAKER | | 16b. Kind of Business/Industry
HOUSEKEEPING-OWN HOME | | | |
| | 17. Father's Name (First, Middle, Last)
VERNON ADAM RIEDEL | | 18. Mother's Name (First, Middle, Maiden Surname)
BERTHA MAE BAKER | | 19a. Informant's Name/Relationship (Type, Print)
FLORENCE G. MORGAN (SISTER) | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
8 AVERY COURT BALTIMORE, MARYLAND 21237 | |
| Physician
/Medical
Examiner | 20a. Method of Disposition
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
PARKWOOD CEMETERY MAY 28, 1996 | | 20c. Location - City or Town, State
BALTIMORE, MARYLAND | | 21. Signature of Funeral Service Licensee
[Signature] | |
| | 22. Name and Address of Facility
LASSAHN FUNERAL HOME, INC.
7401 BELAIR ROAD BALTIMORE, MARYLAND 21236-4625 | | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
Immediate Cause (Final disease or condition resulting in death)
e. <u>Arteriosclerotic Cardiovascular Disease</u>
Due to (or as a consequence of):
b. _____ Due to (or as a consequence of):
c. _____ Due to (or as a consequence of):
d. _____
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | 23b. Did tobacco use contribute to the cause of death?
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | 24a. Was an autopsy performed?
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| Medical Certification: To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner?
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year)
28b. Time of Injury
M 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| | 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | 29a. Certifier (Check only one)
1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | |
| State Registrar | 29b. Signature and title of certifier
[Signature] | | 29c. License number
O.C.M.E. | | 29d. Date signed (Month, Day, Year)
MAY 25, 1996 | | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
JULIAN LOCKE, MD 111 Penn Street, Baltimore, Maryland 21201 | |
| | 31. Date filed (Month, Day, Year)
MAY 30 1996 | | 32. Registrar's Signature
[Signature] | | | | | |



96 15892

FOR STATE REGISTRAR 5/30/96 rebSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
 1 - Item: 1. per F.H. G-735 CERTIFICATE OF DEATH REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
BETTY LEE BOWSER | | | | 2. DATE OF DEATH
MONTH DAY YEAR
MAY 24 1996 | | 3. TIME OF DEATH
1020pm M | |
| 4. SOCIAL SECURITY NUMBER
218-16-1719 | | 5. SEX
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
72 YRS. | | 7. DATE OF BIRTH (Month, Day, Year)
April 24, 1924 | |
| 8. BIRTHPLACE (State or Foreign Country)
Ohio | | | | 9a. FACILITY NAME (If not institution, give street and number)
LaPlata Nursing Home | | 9b. CITY, TOWN OR LOCATION OF DEATH
LaPlata | |
| 9c. COUNTY OF DEATH
Charles | | | | 10a. STATE
Maryland | | | |
| 10b. COUNTY
St. Marys | | 10c. CITY, TOWN OR LOCATION
Mechanicsville | | 10d. INSIDE CITY LIMITS?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | |
| 10e. STREET AND NUMBER
9465 North Riceville Road | | | | 10f. ZIP CODE
20659 | | 10g. CITIZEN OF WHAT COUNTRY?
United States | |
| 11. MARITAL STATUS
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 Years
College (1-4 or 5+) Housewife | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
Housewife | | 16b. KIND OF BUSINESS/INDUSTRY
Own Home | |
| 17. FATHER'S NAME (First, Middle, Last)
Harry Polen | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Adolphine LaMotte | | | |
| 19a. INFORMANT'S NAME (Type/Print)
Mr. Claire Hiram Bowser | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
9465 N. Riceville Road Mechanicsville, MD 20659 | | | |
| 20a. METHOD OF DISPOSITION
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
Oak Lawn Cemetery 5/28/1996 | | 20c. LOCATION — City or Town, State
Baltimore, MD | | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
[Signature] | |
| 22. NAME AND ADDRESS OF FACILITY
Duda-Ruck Funeral Home of Dundalk, Inc.
7922 Wise Ave. Dundalk, MD 21222 | | | | 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. CARDIOPULMONARY ARREST
DUE TO (OR AS A CONSEQUENCE OF):
b. PANCREATIC CA, ENDSTAGE RENAL FAILURE
DUE TO (OR AS A CONSEQUENCE OF):
c. HEPATIC FAILURE, CHOLECYSTECTOMY
DUE TO (OR AS A CONSEQUENCE OF):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | 24a. WAS AN AUTOPSY PERFORMED?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
<input type="checkbox"/> YES <input type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA
OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | 27. MANNER OF DEATH
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation
<input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. CERTIFIER (Check only one)
<input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. SIGNATURE AND TITLE OF CERTIFIER
Adnanham (PHYSICIAN) | | 29c. LICENSE NUMBER
D42632 | | 29d. DATE SIGNED (Month, Day, Year)
5-25-96 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
ASHOK CHAUHAN, 5021, SEMINARY ROAD, SUITE 106, ALEXANDRIA, VA 22311 | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
MAY 30 1996 | | 32. REGISTRAR'S SIGNATURE
[Signature] | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



(E)

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 15893

Physician
/Medical
ExaminerFuneral
Director

| | | | | | | | |
|---|--|--|--|--|--|--|--|
| 1. Decedent's Name (First, Middle, Last)
JOHN BLAKE | | | | 2. Date of Death
Month Day Year
MAY 24, 1996 | | 3. Time of Death
06:51 AM | |
| 4a. Facility Name (If not institution, give street and number)
MARYLAND GENERAL HOSPITAL | | | | 4b. City, Town, or Location of Death
BALTO. | | 4c. County of Death
BALTIMORE CITY | |
| 5. Social Security Number
213 32 6814 | | 6. Sex
1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 7. Age (In yrs. last birthday)
59 Yrs. | | 8. Date of Birth (Month, Day, Year)
10/21/36 | |
| 9. Birthplace (State or Foreign Country)
MD. | | | | | | | |
| Usual Residence of Decedent | | | | | | | |
| 10a. State
MD. | | 10b. County
BALTIMORE CITY | | 10c. City, Town or Location
BALTIMORE | | 10d. Inside City Limits
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| 10e. Street and Number
1221 WEST CROSS ST. | | | | 10f. Zip Code
21230 | | 10g. Citizen of What Country?
USA | |
| 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: BLACK | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (1-4 or 5+) 0 | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
STATION ATTENDANT | | 16b. Kind of Business/Industry
M.T.A. | |
| 17. Father's Name (First, Middle, Last)
JOHN W. TERRY | | | | 18. Mother's Name (First, Middle, Maiden Surname)
REBECCA BLAKE | | | |
| 19a. Informant's Name/Relationship (Type, Print)
PATRICIA BLAKE WIFE | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1221 W. CROSS ST. BALTIMORE, MD. 21230 | | | |
| 20a. Method of Disposition
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
KING'S PARK 5/28/96 | | 20c. Location - City or Town, State
RANDALLSTOWN, MD. | | | |
| 21. Signature of Funeral Service Licensee
<i>[Signature]</i> | | | | 22. Name and Address of Facility
ESTEP BROTHERS FUNERAL HOME P.A.
1300 EUTAW PL. BALTO. MD. 21217 | | | |

To Be Completed by Funeral Director

Physician
/Medical
Examiner

| | | | |
|---|--|--|--|
| 23a. Pertinent disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last | | Approximate Interval Between Onset and Death | |
| a. CARDIOPULMONARY ARREST
Due to (or as a consequence of): | | MINUTES | |
| b. ACUTE MYOCARDIAL INFARCT
Due to (or as a consequence of): | | MINUTES | |
| c. ATHEROSCLEROTIC CARDIOVASCULAR DISEASE
Due to (or as a consequence of): | | YEARS | |
| d. HYPERTENSION
Due to (or as a consequence of): | | YEARS | |

Medical Certification: To Be Completed by Physician/Medical Examiner

| | | | | | |
|--|--|---|--|--|--|
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
(1) END STAGE RENAL DISEASE 2° # (2)
(2) DIABETES MELLITUS | | | | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown | |
| | | | | 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | |
| | | | | 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | |
| 25. Was case referred to medical examiner?
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28. Place of Death (Check only one)
Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | |
| 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation
2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined
3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | |
| | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | |
| | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | |
| 29b. Signature and title of certifier
<i>[Signature]</i> | | 29c. License number
031960 | | 29d. Date signed (Month, Day, Year)
5/29/96 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
LUIS F. GIMENEZ MD 5601 LOCH RAVEN BLVD. (SUITE 208) BALTIMORE MD 21239 | | | | | |
| 31. Date filed (Month, Day, Year)
MAY 30 1996 | | 32. Registrar's Signature
<i>[Signature]</i> | | | |

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 48 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

96 15894

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
CLARENCE EUGENE COX | | | | 2. DATE OF DEATH
MONTH May DAY 25 YEAR 1996 | | 3. TIME OF DEATH
6:50A M | |
| 4. SOCIAL SECURITY NUMBER
233-26-3966 | | 5. SEX
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
73 YRS. | | 7. DATE OF BIRTH (Month, Day, Year)
July 30, 1922 | |
| 9a. FACILITY NAME (If not institution, give street and number)
VA Maryland Health Care Systems | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
Perry Point | | 9c. COUNTY OF DEATH
Cecil | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE
Maryland | | 10b. COUNTY
Baltimore | | 10c. CITY, TOWN OR LOCATION
Fort Howard | | 10d. INSIDE CITY LIMITS?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 10e. STREET AND NUMBER
9425 North Point Road | | | | 10f. ZIP CODE
21052 | | 10g. CITIZEN OF WHAT COUNTRY?
United States | |
| 11. MARITAL STATUS
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO
IF YES, GIVE WAR OR DATES WWII | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12) 8 Years
College (1-4 or 5+) College | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
Electrician | | 16b. KIND OF BUSINESS/INDUSTRY
Railroad | | | |
| 17. FATHER'S NAME (First, Middle, Last)
Clark M. Cox | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Thelma Blanch Horner | | | |
| 19a. INFORMANT'S NAME (Type/Print)
Mrs. Isabel Elizabeth Cox | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
9425 North Pt. Road Fort Howard, Maryland 21052 | | | |
| 20a. METHOD OF DISPOSITION
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
Dulaney Valley Mem. Pk. 5/29/96 Timonium, MD | | 20c. LOCATION — City or Town, State | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
Johnny L. Goble | | | | 22. NAME AND ADDRESS OF FACILITY
Duda-Ruck Funeral Home of Dundalk, Inc.
7922 Wise Ave. Dundalk, MD 21222 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | | a. ACUTE MYOCARDIAL INFARCTION
DUE TO (OR AS A CONSEQUENCE OF): | | | | | |
| Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | b. CORONARY ARTERY DISEASE
DUE TO (OR AS A CONSEQUENCE OF): | | | | | |
| | | c.
DUE TO (OR AS A CONSEQUENCE OF): | | | | | |
| | | d.
DUE TO (OR AS A CONSEQUENCE OF): | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA
OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation
<input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined
<input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M | | 28c. INJURY AT WORK?
<input type="checkbox"/> YES <input type="checkbox"/> NO | |
| | | 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. CERTIFIER (Check only one)
<input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
Thomas Finucan | | | | 29c. LICENSE NUMBER
D32395 | | 29d. DATE SIGNED (Month, Day, Year)
5/25/96 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
THOMAS FINUCAN, M.D. VA Maryland Health Care Systems, Perry Point, MD 21902 | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
MAY 30 1996 | | | | 32. REGISTRAR'S SIGNATURE
John Davidson-Rendell | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

5+1



Handwritten signature and date: MAY 10 1966

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 15895

Certificate of Death

Reg. No.

| | | | | | | | | | |
|---|---|--|---|--------------------------------|---|---|--|--|-----------------------------------|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Lee Cromwell | | | | 2. Date of Death
Month Day Year
May 28, 1996 | | 3. Time of Death
6:35 AM | | |
| | 4a. Facility Name (If not institution, give street and number)
Maryland General Hospital | | | | 4b. City, Town, or Location of Death
Baltimore City | | 4c. County of Death
N/A | | |
| Funeral
Director | 5. Social Security Number
213-26-0504 | 6. Sex
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)
90 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth (Month, Day, Year)
Sept. 17, 1905 | | 9. Birthplace (State or Foreign Country)
Maryland | |
| | Usual Residence of Decedent | | | | 10a. State
MD | | 10b. County
N/A | 10c. City, Town or Location
BALTIMORE | |
| To Be Completed by Funeral Director | 10d. Inside City Limits
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 10e. Street and Number
1701 BUTAW PLACE | | 10f. Zip Code
21217 | | 10g. Citizen of What Country?
USA | | |
| | 11. Marital Status
1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: BLACK | | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 5TH College (1-4or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
MAID | | 16b. Kind of Business/Industry
HOME | | | | |
| | 17. Father's Name (First, Middle, Last)
JOSHUA CROMWELL | | | | 18. Mother's Name (First, Middle, Maiden Surname)
EDITH TURNER | | | | |
| | 19a. Informant's Name/Relationship (Type, Print)
JANEZ GRAVES | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
400 MILLINGTON AVE, RT. 407 BALT, MD, 21223 | | | | |
| | 20a. Method of Disposition
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
MT. ZION CEM. 411/4 LANSDOWNE, MD. | | 20c. Location - City or Town, State
BALT, MD, 21229 | | | | |
| | 21. Signature of Funeral Service Licensee
[Signature] | | | | 22. Name and Address of Facility
GARY P. MARCA FUNERAL HOME P.A.
270 FRED HILTON PASS BALT, MD, 21229 | | | | |
| | 23a. Please enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
Immediate Cause (Final disease or condition resulting in death)
a. Carcinoma of Right Lung w/Bone Metastasis
Due to (or as a consequence of):
b. Ischemic Cardiomyopathy
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | | |
| | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown | | | | | | | | |
| | 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | | | | | |
| Medical Certification: To Be Completed by Physician/Medical Examiner | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Chronic Obstructive Pulmonary Disease | | | | | | | | |
| | 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | | |
| | 26. Place of Death (Check only one)
Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | | |
| | 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide
5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred |
| 29a. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier
Melskaya M.D. | | 29c. License number
89263 | | 29d. Date signed (Month, Day, Year)
May 28, 1996 | | | |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)
Elisaveta Melskaya, M.D. c/o Maryland General Hospital | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
5/28/96 | | 32. Registrar's Signature
Davidson-Randall | | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

ITEMS: 23 PART I, 27, 28a-f, State of Maryland / Department of Health and Mental Hygiene
 PER MEO FILM G-735 5/30/96 t.t

96 15896

Certificate of Death

Reg. No.

| | | | | | | | | |
|---|--|---|---|--|--|---|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
GERALD J. CHIODO | | | | 2. Date of Death
MAY 23 1996 | | 3. Time of Death
2245 PM | |
| | 4a. Facility Name (If not institution, give street and number)
ATLANTIC GENERAL HOSPITAL | | | | 4b. City, Town, or Location of Death
BERLIN | | 4c. County of Death
WORCESTER | |
| Funeral
Director | 5. Social Security Number
132-68-0892 | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)
21 Yrs. | If Under 1 Year
Months Days | 8. Date of Birth (Month, Day, Year)
Aug. 16 1974 | 9. Birthplace (State or Foreign Country)
New York | |
| | Usual Residence of Decedent | | | | 10a. State
New York | | 10b. County
Nassau | |
| To Be Completed by Funeral Director | 10c. City, Town or Location
East Meadow | | | | 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | |
| | 10e. Street and Number
Bernard Street 581 | | | | 10f. Zip Code
11554 | | 10g. Citizen of What Country?
U.S.A. | |
| | 11. Marital Status
<input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: White | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (1-4or 5+) NA | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Carpet Installer | | 16b. Kind of Business/Industry
Carpet Installation | | | |
| | 17. Father's Name (First, Middle, Last)
Gerald Chiodo | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Patricia Grocki | | | |
| | 19a. Informant's Name/Relationship (Type, Print)
Patricia Chiodo / Mother | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Bernard St. 581 East Meadow, N.Y. 11554 | | | |
| | 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Holy Rood Cemetery | | 20c. Date
May 31, 1996 | | 20d. Location - City or Town, State
Westbury, N.Y. | |
| | 21. Signature of Funeral Service Licensee
<i>Mark A. Prosch</i> | | | | 22. Name and Address of Facility
W. Dabrowski/Chojnacki F.H. P.A.
1005 Dundalk Ave. Balt., MD. 21224 | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. HEAD AND NECK INJURIES
Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. { Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | |
| | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | | | | | | |
| 24a. Was an autopsy performed?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | | |
| 25. Was case referred to medical examiner?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | | |
| 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | | |
| 27. Manner of Death
<input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year)
5-25-96 | | 28b. Time of Injury
8:48 P M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
HOTEL | | | | 28d. Describe how injury occurred
SUBJECT FELL OFF RAILING OF HOTEL BALCONY | | | | |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)
AMERICANA MOTOR INN, 513 ATLANTIC AVE. OCEAN CITY, MD. | | | | | | | | |
| 29a. Certifier (Check only one)
<input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | |
| 29b. Signature and title of certifier
<i>Theodore M. King</i> | | | | 29c. License number
O.C.M.E. | | 29d. Date signed (Month, Day, Year)
MAY 27, 1996 | | |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)
THEODORE M. King 111 Penn Street, Baltimore, Maryland 21201 | | | | | | | | |
| 31. Date filed (Month, Day, Year)
MAY 30 1996 | | | | 32. Registrar's Signature
<i>John Davidson-Randall</i> | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
 Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Certificate of Death

Reg. No.

| | | | | | | | | | |
|--|--|--|---|--|--|--|--|---|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
ANTHONY CLARK | | | | 2. Date of Death
Month MAY Day 27 Year 1996 | | 3. Time of Death
7:10 PM | | |
| | 4a. Facility Name (If not institution, give street and number)
3108 LEIGHTON AVE. | | | | 4b. City, Town, or Location of Death
BALTIMORE | | 4c. County of Death
N/A | | |
| Funeral
Director | 5. Social Security Number
214-64-8546 | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)
40 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth
Month, Day, Year
March 18, 1956 | 9. Birthplace (State or Foreign Country)
Maryland | |
| | Usual Residence of Decedent | | | | | | | | |
| To Be Completed by Funeral Director | 10a. State
Maryland | | 10b. County
N/A | | 10c. City, Town or Location
Baltimore | | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | |
| | 10e. Street and Number
3108 Leighton Ave. | | | | 10f. Zip Code
21215 | | 10g. Citizen of What Country?
USA | | |
| | 11. Marital Status
<input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: Negro | | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 10 College (1-4 or 5+) 0 | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Handyman | | 16b. Kind of Business/Industry
Public Service | | | |
| | 17. Father's Name (First, Middle, Last)
Izel Clark | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Virginia Jiggetts | | | | |
| | 19a. Informant's Name/Relationship (Type, Print)
Mr. + Mrs. Izel Clark | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
3108 Leighton Ave. Balto, Md. 21215 | | | | |
| | 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematorium or other place)
Mt. Zion | | 20c. Location - City or Town, State
5/31/96 Lansdowne, Md. | | | | |
| | 21. Signature of Funeral Service Licensee
Joseph L. Russ | | | | 22. Name and Address of Facility
Joseph L. Russ Funeral Home
2222 W. North Ave. Balto, Md. 21216 | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

CIRRHOSIS OF LIVER
Due to (or as a consequence of):

Due to (or as a consequence of):

Due to (or as a consequence of):

Due to (or as a consequence of): | | | | | | | | |
| | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | | | | |
| 24a. Was an autopsy performed?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | | |
| 25. Was case referred to medical examiner?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | | | |
| 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input checked="" type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input type="checkbox"/> No | | 28d. Describe how injury occurred | |
| 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| 29a. Certifier (Check only one)
<input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | |
| 29b. Signature and title of certifier
Winnie D. Howell | | | | 29c. License number
O.C.M.E. | | 29d. Date signed (Month, Day, Year)
MAY 28, 1996 | | | |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)
Mary Ann A. Kowen Mr. 111 Penn Street, Baltimore, Maryland 21201 | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
MAY 30 1996 | | | | 32. Registrar's Signature
John Rendell | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 15898

Certificate of Death

Reg. No.

Item: 1, per F.H. G-235 5/30/96 reb

| | | | | | | | | |
|--|---|---|---|--|---|---|---|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
JOSEPH Raymond J. Celio | | | | 2. Date of Death
Month 5 Day 26 Year 96 | | 3. Time of Death
12:10AM | |
| | 4a. Facility Name (If not Institution, give street and number)
Johns Hopkins Bayview Medical Ctr. | | | | 4b. City, Town, or Location of Death
Baltimore City | | 4c. County of Death
N/A | |
| Funeral
Director | 5. Social Security Number
216-10-4194 | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday)
78 Yrs. | | 8. Date of Birth (Month, Day, Year)
Jan. 20, 1918 | |
| | 9. Birthplace (State or Foreign Country)
Pennsylvania | | 10a. State
Maryland | | 10b. County
Baltimore | | 10c. City, Town or Location
Eastwood | |
| To Be Completed by Funeral Director | 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 10e. Street and Number
7327 Conley Street | | 10f. Zip Code
21224 | | 10g. Citizen of What Country?
United States | |
| | 11. Marital Status
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
If Yes, Give Year or Dates: WWII | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: White | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 8 Years | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Burner | | 16b. Kind of Business/Industry
Ship Building | | | |
| | 17. Father's Name (First, Middle, Last)
Vincent Celio | | 18. Mother's Name (First, Middle, Maiden Summa)
Mary DiGuillo | | 19a. Informant's Name/Relationship (Type, Print)
Mrs. Grace Elizabeth Celio | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
7327 Conley Street Eastwood, Maryland 21224 | |
| | 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Oak Lawn Cemetery 5/30/1996 | | 20c. Location - City or Town, State
Baltimore, MD | | | |
| | 21. Signature of Funeral Service Licensee
 | | 22. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk, Inc.
7922 Wise Ave. Dundalk, MD 21222 | | 23a. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
lung cancer | | Approximate Interval Between Onset and Death | |
| | 23b. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
lung cancer | | 23c. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | 23d. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | 23e. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | |
| | 23f. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | 23g. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | 23h. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | 23i. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | |
| | 23j. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | 23k. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | 23l. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | 23m. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | |
| | 23n. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | 23o. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | 23p. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | 23q. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | |
| | | | | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | |
| | | | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation
<input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined
<input type="checkbox"/> Suicida <input type="checkbox"/> Homicida | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| | | 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28d. Describe how injury occurred | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier
 | | 29c. License number
D47009 | | 29d. Date signed (Month, Day, Year)
5/26/96 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Phillip Stone Johns Hopkins Bayview 4940 Eastern Ave. Baltimore, MD | | | | | | | | |
| 31. Date filed (Month, Day, Year)
MAY 30 1996 | | 32. Registrar's Signature
 | | | | | | |

96 15899

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|--|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
Richard L. CRAIG, Jr. | | | | 2. DATE OF DEATH
MONTH DAY YEAR
MAY 27 96 | | 3. TIME OF DEATH
7:00 A M | |
| 4. SOCIAL SECURITY NUMBER
212-56-2734 | | 5. SEX
1 M 2 F | | 6. AGE (In yrs. last birthday)
45 YRS. | | 7. DATE OF BIRTH (Month, Day, Year)
Oct. 16, 1950 | |
| 8. BIRTHPLACE (State or Foreign Country)
MD | | | | 9a. FACILITY NAME (If not institution, give street and number)
Bons Secours Hospital | | 9b. CITY, TOWN OR LOCATION OF DEATH
Baltimore | |
| 9c. COUNTY OF DEATH
N/A | | | | 10a. STATE
MD | | | |
| 10b. COUNTY
n/a | | | | 10c. CITY, TOWN OR LOCATION
Baltimore | | | |
| 10d. INSIDE CITY LIMITS?
<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | | | 10e. STREET AND NUMBER
249 N. Payson St. | | | |
| 10f. ZIP CODE
21223 | | | | 10g. CITIZEN OF WHAT COUNTRY?
USA | | | |
| 11. MARITAL STATUS
<input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No - If yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE - American Indian, Black, White, etc.
Specify: Black | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12) 12th College (1-4 or 5+) College | | | | 16. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
Auto Mechanic | | 16b. KIND OF BUSINESS/INDUSTRY
Auto | |
| 17. FATHER'S NAME (First, Middle, Last)
Richard L. Craig, Sr. | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Lillian Thornhill | | | |
| 19a. INFORMANT'S NAME (Type/Print)
Lillian Craig | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
249 N. Payson St. Balto., MD 21223 | | | |
| 20a. MANNER OF DISPOSITION
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
Arbutus Memorial Park 5/31 | | 20c. LOCATION - City or Town, State
Baltimore, MD | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
James A. Morton | | | | 22. NAME AND ADDRESS OF FACILITY
James A. Morton & Sons Funeral Home
1701 Laurens St. Balto., MD 21217 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

IMMEDIATE CAUSE (Final disease or condition resulting in death) → Sepsis

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
CHRONIC RENAL FAILURE URS. ACCESS IN ACOTIA
HYPERTENSIVE NEPHROCLEROSIS | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Dementia CEREBRAL Atrophy
20 to Alcoholic | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA
OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | |
| 27. MANNER OF DEATH
1 <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation
2 <input type="checkbox"/> Accident <input type="checkbox"/> Suicide
3 <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M | |
| 28c. INJURY AT WORK?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | 28d. DESCRIBE HOW INJURY OCCURRED | | | |
| 28e. PLACE OF INJURY - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one)
1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
Dr. [Signature] MD | | | | 29c. LICENSE NUMBER
D-21420 | | 29d. DATE SIGNED (Month, Day, Year)
27 MAY | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27 Type, Print)
CURTIS DAVIS MD BON Secours Hosp 21223 | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
MAY 30 1996 | | | | 32. REGISTRAR'S SIGNATURE
[Signature] | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 6876

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 15900

Certificate of Death

Reg. No.

| | | | | | | | | | | |
|---|---|--|---|-------------------------------|--|--|--|---|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
William Ross Carew | | | | 2. Date of Death
Month May 24, Day 1996 Year | | | | 3. Time of Death
2:00 AM | |
| | 4a. Facility Name (If not Institution, give street and number)
715 MAIDEN CHOICE LANE, HV109 | | | | 4b. City, Town, or Location of Death
CATONSVILLE | | | | 4c. County of Death
BALTIMORE | |
| Funeral
Director | 5. Social Security Number
577-09-2118 | | 6. Sex
1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 7. Age (In yrs. last birthday)
85 Yrs. | | 8. Date of Birth (Month, Day, Year)
MAY 1, 1911 | | 9. Birthplace (State or Foreign Country)
MARYLAND | |
| | Usual Residence of Decedent | | | | 10a. State
MD | | 10b. County
BALTIMORE | | 10c. City, Town or Location
CATONSVILLE | |
| To Be Completed by Funeral Director | 10e. Street and Number
715 MAIDEN CHOICE LN., HV109 | | 10f. Zip Code
21228 | | 10g. Citizen of What Country?
U.S.A. | | 10d. Inside City Limits
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | |
| | 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: WHITE | | | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) College (1-4or 5+)
4 | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
SUPERVISOR | | 16b. Kind of Business/Industry
WESTERN ELECTRIC | | | | | |
| | 17. Father's Name (First, Middle, Last)
WILLIAM FRANCIS CAREW | | | | 18. Mother's Name (First, Middle, Maiden Surname)
CATHERINE BUTLER | | | | | |
| | 19a. Informant's Name/Relationship (Type, Print)
S. MARGARET CAREW, WIFE | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
715 MAIDEN CHOICE LN., CATONSVILLE, MD 21228 | | | | | |
| | 20a. Method of Disposition
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
NEW CATHEDRAL CEMETERY 5/28 | | 20c. Location - City or Town, State
BALTIMORE, MD | | | | | |
| | 21. Signature of Funeral Service Licensee
<i>Phillip Starks</i> | | | | 22. Name and Address of Facility
Sterling Ashton Funeral Home, Inc.
736 Edmondson Ave. Balto. MD. 21228 | | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
Immediate Cause (Final disease or condition resulting in death)
e. METASTATIC COLON CANCER
Due to (or as a consequence of):
Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. | | | | | | | | | |
| | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | | | | | | | |
| | 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | | | | |
| Medical Certification: To Be Completed by Physician/Medical Examiner | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
MULTIPLE MYELOMA | | | | | | | | | |
| | 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | | | |
| | 26. Place of Death (Check only one)
Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | | | |
| | 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide
5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how Injury occurred | |
| | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | | | |
| 29b. Signature and title of certifier
<i>Matthew J. Nunez M.D.</i> | | | | 29c. License number
D44748 | | | | 29d. Date signed (Month, Day, Year)
May 24, 1996 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
MATTHEW J. NUNEZ 715 MAIDEN CHOICE LANE CATONSVILLE, MD 21228 | | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
MAY 3 01996 | | | | | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 24a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

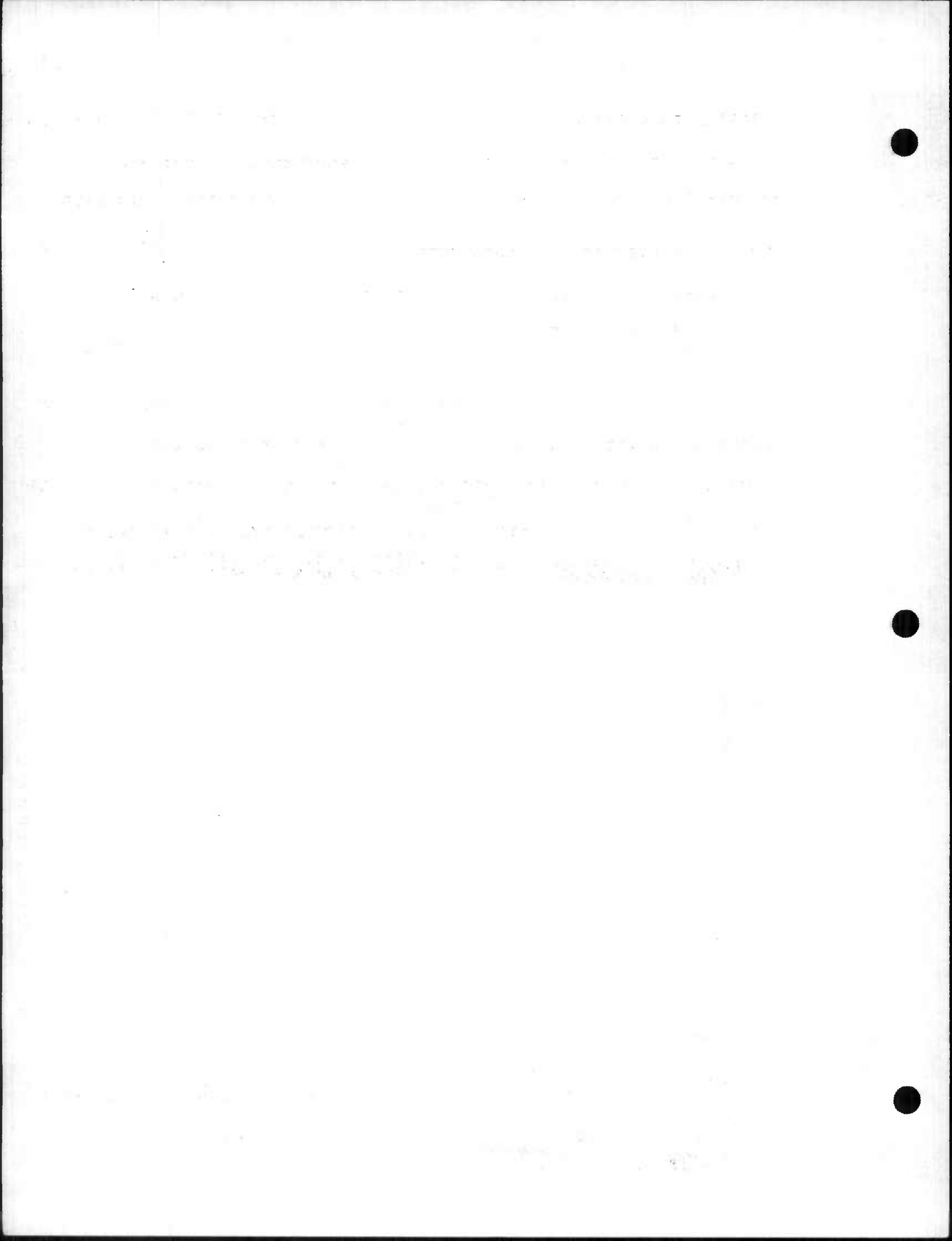
Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and immediately filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

State
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 15901

Certificate of Death

Reg. No.

| | | | | | | | | | | | |
|---|--|--|--|--|---|--|--|--|--|--|---|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
GLORIA JUNE COLBURN | | | | 2. Date of Death
Month Day Year
MAY 26 1996 | | | | 3. Time of Death
1:30 P.M. | | |
| | 4a. Facility Name (If not institution, give street and number)
HART HERITAGE HOME | | | | 4b. City, Town, or Location of Death
STREET | | | | 4c. County of Death
HARFORD | | |
| Funeral
Director | 5. Social Security Number
212-22-8623 | | 6. Sex
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday)
73 Yrs. | | 8. Date of Birth (Month, Day, Year)
11/28/22 | | 9. Birthplace (State or Foreign Country)
MARYLAND | | |
| | Usual Residence of Decedent | | | | 10c. City, Town or Location
RIDGELEIGH | | 10d. Inside City Limits
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | |
| To Be Completed by Funeral Director | 10e. State
MARYLAND | | 10b. County
BALTIMORE | | 10f. Zip Code
21234 | | | | 10g. Citizen of What Country?
USA | | |
| | 10e. Street and Number
8615 ROCK OAK ROAD | | 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: WHITE | | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12)
12th GRADE | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
CLERK | | 16b. Kind of Business/Industry
BALTO. CO. DEEDS DEPT. | | | | | | |
| | 17. Father's Name (First, Middle, Last)
CLARENCE LANDIS | | | | 18. Mother's Name (First, Middle, Maiden Surname)
BIRDIE STONEBREAKER | | | | | | |
| | 19a. Informant's Name/Relationship (Type, Print)
CHARLES COLBURN SON | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
607 DORSEY ROAD BEL AIR, MD 21014 | | | | | | |
| | 20a. Method of Disposition
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
GARDENS OF FAITH | | Date
5/29/96 | | 20c. Location - City or Town, State
PARKVILLE, MD | | | | |
| | 21. Signature of Funeral Service Licensee
Christina L. Kopych | | | | 22. Name and Address of Facility
JOHNSON FUNERAL HOME
8521 LOCH RAVEN BLVD. TOWSON, MD 21286 | | | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | | | | Approximate Interval Between Onset and Death |
| | Immediate Cause (Final disease or condition resulting in death)
a. congestive Heart Failure
Due to (or as a consequence of):
b. Coronary Artery Disease
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d. | | | | | | | | | | years
years |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Chronic Obstructive Pulmonary Disease
Asthma | | | | | | | | | | 23b. Did tobacco use contribute to the cause of death?
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown
24e. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |
| 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | | | | 28. Place of Death (Check only one)
28e. Date of Injury (Month, Day, Year)
28b. Time of Injury
28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
28d. Describe how injury occurred
28f. Location (Street and Number or Rural Route Number, City or Town, State) | |
| 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide
5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | | | | | | | | | 29a. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | |
| 29b. Signature and title of certifier
Lee Tannenbaum M.D.
29c. License number
D39763
29d. Date signed (Month, Day, Year)
5/28/96 | | | | | | | | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Lee Tannenbaum, MD 2012 Tollgate Rd, Suite 102 Bel Air, MD 21015 | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
MAY 30 1996 | | | | | | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 24a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

to the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

10

State
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 15902

Certificate of Death

Reg. No.

| | | | | | | | | | |
|---|---|--|--|---|--|---------------------------------|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
CHARLES Donald CAIN, SR | | | | 2. Date of Death
Month Day Year
MAY 25 1996 | | 3. Time of Death
4:50 am | | |
| | 4a. Facility Name (If not institution, give street and number)
SAINT JOSEPH MEDICAL CENTER | | | | 4b. City, Town, or Location of Death
TOWSON | | 4c. County of Death
BALTIMORE | | |
| Funeral
Director | 5. Social Security Number
213-10-3795 | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)
92 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth (Month, Day, Year)
Nov. 24, 1903 | 9. Birthplace (State or Foreign Country)
Balto. Md. | |
| | Usual Residence of Decedent | | | | 10a. State
Maryland | | 10b. County
Baltimore Co. | | |
| To Be Completed by Funeral Director | 10c. City, Town or Location
Lutherville | | | | 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 10e. Street and Number
231 East Ridgely Road | | |
| | 10f. Zip Code
21093 | | | | 10g. Citizen of What Country?
United States | | 11. Marital Status
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | |
| | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: White | | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 10 College (1-4or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Electrician | | 16b. Kind of Business/Industry
Rubber Manufacturing | | |
| | 17. Father's Name (First, Middle, Last)
Charles Richard Cain | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Anna Catherine Weigert | | | | |
| | 19a. Informant's Name/Relationship (Type, Print)
Margaret A. Meinecke (Daughter) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
231 East Ridgely Road Lutherville, Md. 21093 | | | | |
| | 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Gardens of Faith Cem. | | 20c. Location - City or Town, State
5/29/96 Rossville, Maryland | | |
| | 21. Signature of Funeral Service Licensee
Jeffrey L. Gair | | | | 22. Name and Address of Facility
Ruck Towson Funeral Home, Inc.
1050 York Road Towson, Maryland 21204 | | | | |
| | 23a. Part I. Enter the disease or conditions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. ASPIRATION PNEUMONIA
Due to (or as a consequence of):

b. PULMONARY EDEMA
Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of): | | | | Approximate Interval Between Onset and Death
6 days
6 days | | | | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
DIABETES MELLITUS | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | | | |
| 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No | | | | | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one)
Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input type="checkbox"/> No | |
| 28d. Describe how injury occurred | | | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Certifying Physician: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | 29b. Signature and title of certifier
Joginder P Mehta M.D. | | | | 29c. License number
D 41410 | |
| 29d. Date signed (Month, Day, Year)
MAY 25, 96. | | | | 30. Name and address of person who completed causa of death (Item 23a) (Type, Print)
JOGINDER P MEHTA, MD 7620 YORK ROAD TOWSON, MARYLAND 21204 | | | | 31. Date filed (Month, Day, Year)
MAY 30 1996 | |
| 31. Registrar's Signature
J. Davidson-Rodriguez | | | | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

[The page contains extremely faint, illegible markings and bleed-through from the reverse side.]

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 15903

Certificate of Death

Reg. No.

| | | | | | | | | |
|---|---|--|---|--|--|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Adelina Genovese DiPietro | | | | 2. Date of Death
Month Day Year
May 27, 1996 | | 3. Time of Death
9:05 a.m. | |
| | 4a. Facility Name (If not institution, give street and number)
1125 Daniels Avenue | | | | 4b. City, Town, or Location of Death
Woodlawn | | 4c. County of Death
Baltimore | |
| Funeral
Director | 5. Social Security Number
212-03-9086 | | 6. Sex
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday)
98 Yrs. | | 8. Date of Birth (Month, Day, Year)
6-18-1897 | |
| | 9. Birthplace (State or Foreign Country)
Italy | | 10a. State
Md. | | 10b. County
Baltimore | | 10c. City, Town or Location
Woodlawn | |
| To Be Completed by Funeral Director | 10d. Inside City Limits
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 10e. Street and Number
1125 Daniels Avenue | | 10f. Zip Code
21207 | | 10g. Citizen of What Country?
U.S.A. | |
| | 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: White | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) Grade 8
College (1-4 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Seamstress | | 16b. Kind of Business/Industry
Mens Clothing Factory | | | |
| | 17. Father's Name (First, Middle, Last)
Reginaldo Genovese | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Teresina DeFranco | | | |
| | 19a. Informant's Name/Relationship (Type, Print)
Martin Yannuzzi | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
8507 Willow Oak Rd.-Baltimore, Md. 21234 | | | |
| | 20a. Method of Disposition
1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input checked="" type="checkbox"/> Other (Specify) Entombment | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Lorraine Pk. Cemetery 5+30-96 | | 20c. Location - City or Town, State
Woodlawn, Md. | | | |
| | 21. Signature of Funeral Service Licensee
G. Truman Schwab | | 22. Name and Address of Facility
5151 Baltimore National Pike
Baltimore, Md. 21229 | | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
Immediate Cause (Final disease or condition resulting in death)
Congestive Heart Failure
Due to (or as a consequence of):
Coronary artery Disease
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Advanced Age | | | | | | | |
| | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | | | | | |
| | 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | | | | |
| To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one)
Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA
Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify) | | | |
| | 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide
5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| | 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| | 29a. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| State Registrar | 29b. Signature and title of certifier
R. Liberto, M.D. | | | | 29c. License number
D2464 | | 29d. Date signed (Month, Day, Year)
5/30/96 | |
| | 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)
3508 BANK ST BALTO, MD 21224 - Robert T. Liberto | | | | | | | |
| 31. Date filed (Month, Day, Year)
MAY 30 1996 | | | | 32. Registrar's Signature
[Signature] | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 15904

Item: 1, per F.H. G-735 5/30/96 reb

Certificate of Death

Reg. No.

| | | | | | |
|---|---|--|---|--------------------------------|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
MINNIE LUCILLE DAUGHTON | | 2. Date of Death
Month MAY Day 28 Year 1996 | | 3. Time of Death
1:15 AM |
| | 4a. Facility Name (If not institution, give street and number)
Good Samaritan Hospital | | 4b. City, Town, or Location of Death
Baltimore | | 4c. County of Death
N/A |
| Funeral
Director | 5. Social Security Number
217-24-2277 | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)
67 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. |
| | 8. Date of Birth (Month, Day, Year)
October 18, 1928 | | 9. Birthplace (State or Foreign Country)
Maryland | | |
| To Be Completed by Funeral Director | 10a. State
Maryland | | 10b. County
N/A | | 10c. City, Town or Location
Baltimore |
| | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | |
| | 10e. Street and Number
3301 White Avenue | | 10f. Zip Code
21214 | | 10g. Citizen of What Country?
United States |
| | 11. Marital Status
<input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |
| | 14. Race - American Indian, Black, White, etc.
Specify: White | | | | |
| To Be Completed by Physician/Medical Examiner | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (1-4 or 5+) 2 | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Clerical | | 16b. Kind of Business/Industry
C.P.A. Firm |
| | 17. Father's Name (First, Middle, Last)
Edward John Daughton | | 18. Mother's Name (First, Middle, Maiden Surname)
Hazel Jeannette Fletcher | | |
| | 19a. Informant's Name/Relationship (Type, Print)
M. Arlene Hardesty/ sister | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
3301 White Avenue Baltimore, Maryland 21214 | | |
| | 20a. Method of Disposition
<input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Hilltop Service Corporation | | Date 5/30/96 |
| | 20c. Location - City or Town, State
Towson, Maryland | | | | |
| To Be Completed by Physician/Medical Examiner | 21. Signature of Funeral Service Licensee
Brian A. Willem | | 22. Name and Address of Facility
Leonard J. Ruck Funeral Home, Inc.
5305 Harford Road Baltimore, Maryland 21214 | | |
| | 23a. Pert I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | |
| | Immediate Cause (Final disease or condition resulting in death)
CARDIOGENIC SHOCK | | | | |
| | Due to (or as a consequence of):
ACUTE MYOCARDIAL INFARCTION | | | | |
| | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
2 DAYS | | | | |
| To Be Completed by Physician/Medical Examiner | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | |
| | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | |
| | 24a. Was an autopsy performed?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | |
| | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | |
| | 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | |
| To Be Completed by Physician/Medical Examiner | 26. Place of Death (Check only one)
Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | |
| | 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M |
| | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | | |
| | 28e. Place of Injury - At home, term, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | |
| | 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | |
| State Registrar | 29b. Signature and title of certifier
HOUSE STAFF | | 29c. License number
P05300 | | 29d. Date signed (Month, Day, Year)
MAY 28, 1996 |
| | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
GAMAZIO P. BATALLA, MD - GOOD SAMARITAN HOSPITAL | | | | |
| State Registrar | 31. Date filed (Month, Day, Year)
MAY 30 1996 | | 32. Registrar's Signature
John Andrew Ruck | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 15905

Certificate of Death

Reg. No.

| | | | | | | | | |
|--|---|--|---|--|---|--|---|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
NICHOLAS DOHONY | | | | 2. Date of Death
Month MAY Day 25 Year 96 | | 3. Time of Death
5AM | |
| | 4a. Facility Name (If not institution, give street and number)
St. Agnes Hospital | | | | 4b. City, Town, or Location of Death
Baltimore | | 4c. County of Death
N/A | |
| Funeral
Director | 5. Social Security Number
219-36-3615 | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday)
85 Yrs. | | 8. Date of Birth (Month, Day, Year)
November 24, 1910 | |
| | 9. Birthplace (State or Foreign Country)
Maryland | | 10a. State
Maryland | | 10b. County
Howard County | | 10c. City, Town or Location
Ellicott City | |
| Usual Residence of Decedent | | | | | | | | |
| 10a. State
Maryland | | | 10b. County
Howard County | | | 10c. City, Town or Location
Ellicott City | | |
| 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | 10e. Street and Number
3004 North Ridge Road | | | 10f. Zip Code
21043 | | |
| 10g. Citizen of What Country?
USA | | | 11. Marital Status
<input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | |
| 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc.
Specify: white | | | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 4 Collegiate (1-4 or 5+) | | |
| 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Monsignor | | | 16b. Kind of Business/Industry
Catholic Church | | | 17. Father's Name (First, Middle, Last)
Nicholas W. Dohony, Sr. | | |
| 18. Mother's Name (First, Middle, Maiden Surname)
Cecelia Creaghan | | | 19a. Informant's Name/Relationship (Type, Print)
Miss Catherine Dohony/sister | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
3815 Hamilton Avenue, Baltimore, Maryland 21205 | | |
| 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Most Holy Redeemer | | | 20c. Location - City or Town, State
5-28-96 Baltimore, MD | | |
| 21. Signature of Funeral Service Licensee
 | | | 22. Name and Address of Facility
Slack Funeral Home, P.A.
M00535 Ellicott City, Maryland 21043 | | | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
Metastatic Bronchogenic Carcinoma | | |
| 23b. Did tobacco use contribute to the cause of death?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | 26. Place of Death (Check only one)
Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | 27. Manner of Death
<input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | |
| 28a. Date of Injury (Month, Day Year) | | | 28b. Time of Injury
M | | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 28d. Describe how injury occurred | | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | 29b. Signature and title of certifier
 | | | 29c. License number
044701 | | |
| 29d. Data signed (Month, Day, Year)
May 25, 96 | | | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
PAIRACH PINTA WORN
ST AGNES HOSPITAL, BALTIMORE MD | | | 31. Date filed (Month, Day, Year)
MAY 30 1996 | | |
| 32. Registrar's Signature
 | | | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

96 15906

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|---|---|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
Donald Webster Dowell | | | | 2. DATE OF DEATH
MONTH DAY YEAR
May 28 1996 | | 3. TIME OF DEATH
3:30 p.m. | |
| 4. SOCIAL SECURITY NUMBER
215-46-6779 | | 5. SEX
1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | 6. AGE (In yrs. last birthday)
49 YRS. | 7. DATE OF BIRTH (Month, Day, Year)
June 28 1947 | | 8. BIRTHPLACE (State or Foreign Country)
Virginia | |
| 9a. FACILITY NAME (If not institution, give street and number)
Woodlynn Rd. 952 | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
Essex | | 9c. COUNTY OF DEATH
Baltimore | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE
Maryland | | 10b. COUNTY
Baltimore | | 10c. CITY, TOWN OR LOCATION
Essex | | 10d. INSIDE CITY LIMITS?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 10a. STREET AND NUMBER
Woodlynn Road 952 | | | | 10f. ZIP CODE
21221 | | 10g. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 11. MARITAL STATUS
1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO
IF YES, GIVE WAR OR DATES
Vietnam Era | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify:
White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12) College (1-4 or 5+)
12 NA | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
Installer | | 16b. KIND OF BUSINESS/INDUSTRY
Carpet | |
| 17. FATHER'S NAME (First, Middle, Last)
Bernard Dowell | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Judy Samuels | | | |
| 19a. INFORMANT'S NAME (Type/Print)
Deborah Dowell / Wife | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Woodlynn Rd. 952 Essex, Maryland 21221 | | | |
| 20a. METHOD OF DISPOSITION
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
Sacred Heart of Jesus May 31 | | 20c. LOCATION — City or Town, State
Dundalk, Maryland | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
<i>Mark A. Roynack</i> | | | | 22. NAME AND ADDRESS OF FACILITY
W. Dabrowski / Chojnacki F.H. P. A.
1005 Dundalk Ave. Balt., MD. 21224 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Arteriosclerotic Cardiovascular Disease</i>
DUE TO (OR AS A CONSEQUENCE OF):
Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST
b. DUE TO (OR AS A CONSEQUENCE OF):
c. DUE TO (OR AS A CONSEQUENCE OF):
d. | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA
OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH
1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation
2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined
3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 28c. INJURY AT WORK?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. CERTIFIER (Check only one)
1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
<i>Charles F. O'Donnell MD</i> | | | | 29c. LICENSE NUMBER
D-09383 | | 29d. DATE SIGNED (Month, Day, Year)
5-28-96 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
<i>Charles F. O'Donnell MD - 111 Hamlet Hill Rd Baltimore MD</i> | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
MAY 30 1996 | | | | 32. REGISTRAR'S SIGNATURE
<i>John Davidson-Randall</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 15907

Certificate of Death

Reg. No.

| | | | | | | | |
|---|---|--------------------|--|--|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
VINCENT CORTEZ DUFFY Sr. | | | 2. Date of Death
Month Day Year
May 26 1996 | | 3. Time of Death
9:50 AM | |
| | 4a. Facility Name (If not institution, give street and number)
1227 N. LUZERNE AE RES. (MERCY HOSPICE) | | | 4b. City, Town, or Location of Death
BALTIMORE | | 4c. County of Death
n/a | |
| Funeral
Director | 5. Social Security Number
212-46-9188 | | 6. Sex
1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | 7. Age (In yrs. last birthday)
47 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth
(Month, Day, Year)
SEPT. 16, 1948 |
| | 9. Birthplace (State or Foreign Country)
BALTIMORE, MD | | | | | | |
| To Be Completed by Funeral Director | Usual Residence of Decedent | | | | | | |
| | 10a. State
MD | 10b. County
n/a | 10c. City, Town or Location
BALTIMORE | | | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | |
| | 10e. Street and Number
1227 N. LUZERNE AVENUE | | | 10f. Zip Code
21213 | | 10g. Citizen of What Country?
UNITED STATES | |
| | 11. Marital Status
1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: BLACK |
| | 15. Decedent's Education
(Specify only highest grade completed)
Elementary/Secondary (0-12) 12th College (1-4or 5+) | | 18a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)
LABORER | | 16b. Kind of Business/Industry
HOME IMPROVEMENT | | |
| | 17. Father's Name (First, Middle, Last)
WILLIAM M. DUFFY | | | 18. Mother's Name (First, Middle, Maiden Surname)
NELLIE A. BAKER | | | |
| | 19a. Informant's Name/Relationship (Type, Print)
TIFFANEY TOULSON | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1014 DRUID HILL AVENUE, BALTIMORE, MD 21201 | | | |
| | 20a. Method of Disposition
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
WESTERN STAR CEMETERY | | Data
5-30 | 20c. Location - City or Town, State
CATONSVILLE, MD | |
| | 21. Signature of Funeral Service Licensee
Bernard D. Johnson | | | 22. Name and Address of Facility
WM. C. MARCH FH.-1101 E. NORTH AVENUE | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
Immediate Cause (Final disease or condition resulting in death)
a. BILIARY CANCER
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. | | | | | | |
| Approximate Interval Between Onset and Death
1 mo. | | | | | | | |
| Physician
/Medical
Examiner | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
AIDS | | | | | | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |
| | | | | | | | 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |
| | 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) stella maris at mercy HOSPICE
Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | |
| | 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation
2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined
3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| | | | 28d. Describe how injury occurred | | 28e. Location (Street and Number or Rural Route Number, City or Town, State) | | |
| | 29a. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | |
| | 29b. Signature and title of certifier
Dr. J. J. Johnson | | | 29c. License number
D40480 | | 29d. Date signed (Month, Day, Year)
May 28, 1996 | |
| | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
FERNANDO J. FERRO, MD 5810 Belair Rd. BA MD, MD 21206 | | | | | | |
| | 31. Date filed (Month, Day, Year)
MAY 30 1996 | | 32. Registrar's Signature
J. J. Johnson | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 15908

Certificate of Death

Reg. No.

| | | | | | | | | |
|---|--|--|---|--|--|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
<i>Oscar Eisenberg</i> | | | 2. Date of Death
Month <i>May</i> Day <i>23</i> Year <i>1996</i> | | 3. Time of Death
<i>11:08 PM</i> | | |
| | 4a. Facility Name (If not Institution, give street and number)
<i>Suburban Hospital</i> | | | 4b. City, Town, or Location of Death
<i>Bethesda</i> | | 4c. County of Death
<i>Montgomery</i> | | |
| Funeral
Director | 5. Social Security Number
<i>053-05-5537</i> | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)
<i>79</i> Yrs. | If Under 1 Year
Months Days | 8. Date of Birth (Month, Day, Year)
<i>Sept. 25, 1916</i> | 9. Birthplace (State or Foreign Country)
<i>New York</i> | |
| | Usual Residence of Decedent | | | 10a. State
<i>Maryland</i> | | 10b. County
<i>Montgomery</i> | | |
| To Be Completed by Funeral Director | 10c. City, Town or Location
<i>Rockville</i> | | | 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 10e. Street and Number
<i>6121 Montrose Road</i> | | |
| | 10f. Zip Code
<i>20852</i> | | | 10g. Citizen of What Country?
<i>U.S.A.</i> | | 11. Marital Status
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | |
| | 12. Was Decedent Ever in U.S. Armed Forces?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
If Yes, Give Year or Dates: <i>1941-1945</i> | | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: <i>White</i> | | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) <i>2</i> College (1-4 or 5+) | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
<i>Manager</i> | | 16b. Kind of Business/Industry
<i>Poultry Company</i> | | |
| | 17. Father's Name (First, Middle, Last)
<i>Abraham Eisenberg</i> | | | 18. Mother's Name (First, Middle, Maiden Surname)
<i>Pauline Siegel</i> | | | | |
| | 19a. Informant's Name/Relationship (Type, Print)
<i>Barbara Fink</i> | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
<i>105 Quay Street, Alexandria, Va. 22314</i> | | | | |
| | 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
<i>Arlington National Cem.</i> | | 20c. Location - City or Town, State
<i>5-29 Arlington, Va.</i> | | |
| | 21. Signature of Funeral Service Licensee
<i>Lisa D. Williams</i> | | | 22. Name and Address of Facility
<i>Ives-Pearson Funeral Homes
Falls Church, Va. 22046</i> | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

<i>Multi-system Organ Failure</i>
Due to (or as a consequence of):
<i>Congestive Heart Failure</i>
Due to (or as a consequence of):
<i>Cardiomyopathy</i>
Due to (or as a consequence of): | | | | | | | Approximate Interval Between Onset and Death
<i>2 days</i>
<i>10 hrs - standing</i>
<i>long study</i> |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
<i>Sepsis</i>
<i>Pneumonia</i> | | | | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |
| 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | 26. Place of Death (Check only one)
Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
<i>M</i> | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 28d. Describe how injury occurred | | | 28e. Place of Injury - At home, farm, street, tectory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | 29b. Signature and title of certifier
<i>Dr. Karl Kueft MD</i> | |
| 29c. License number
<i>D 21435</i> | | | | | | | 29d. Date signed (Month, Day, Year)
<i>May 24, 1996</i> | |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)
<i>Ira Paul Kretting MD 2101 Medical Park Drive Silver Spring 20902</i> | | | | | | | | |
| 31. Date filed (Month, Day, Year)
<i>MAY 30 1996</i> | | | | | | | 32. Registrar's Signature
<i>Julia Paulson-Randall</i> | |

Baltimore, Maryland 21215-0020

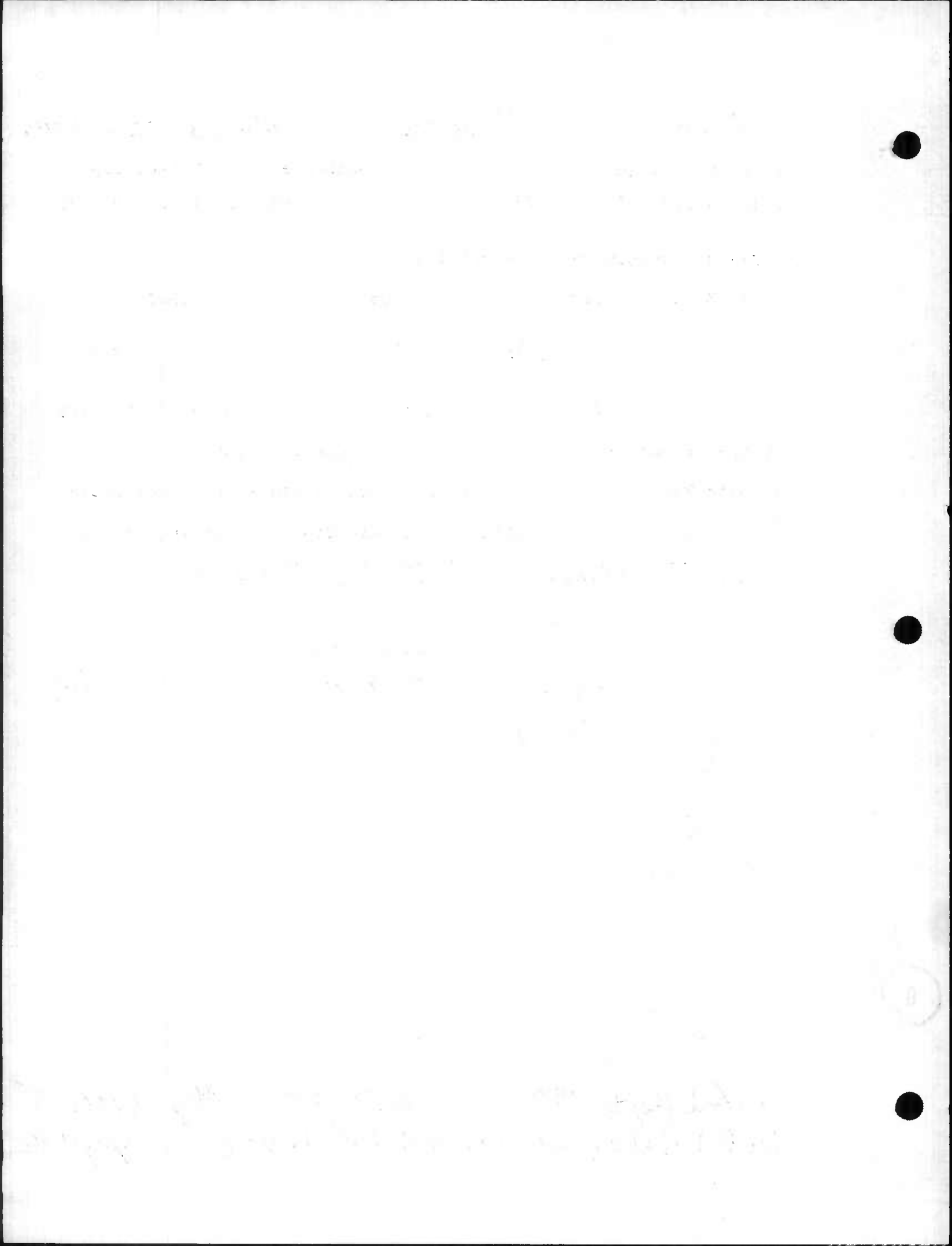
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 15909

Certificate of Death

Reg. No.

| | | | | | | | | |
|--|---|--|---|---|--|--|---|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Carolina Irene Forthuber | | | | 2. Date of Death
Month Day Year
May 26 1996 | | 3. Time of Death
3:45 pm | |
| | 4a. Facility Name (If not institution, give street and number)
Stella Maris Hospice | | | | 4b. City, Town, or Location of Death
Towson | | 4c. County of Death
Baltimore | |
| Funeral
Director | 5. Social Security Number
212-74-8748 | | 6. Sex
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday)
101 Yrs. | | 8. Date of Birth (Month, Day, Year)
7-8-1894 | |
| | 10a. State
Maryland | | 10b. County
Baltimore | | 10c. City, Town or Location
Towson | | 10d. Inside City Limits
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | |
| To Be Completed by Funeral Director | Usual Residence of Decedent
10e. Street and Number
2300 Dulaney Valley Road | | | | 10f. Zip Code
21204 | | 10g. Citizen of What Country?
U.S.A. | |
| | 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: White | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12)
9 | | College (1-4 or 5+)
College | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Homemaker | | 16b. Kind of Business/Industry
Own Home | |
| | 17. Father's Name (First, Middle, Last)
Martin J. Wurst | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Alma A. Bruckner | | | |
| | 19a. Informant's Name/Relationship (Type, Print)
Raymond F. Forthuber (Son) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
13911 Green Branch Drive, Phoenix, Maryland 21131 | | | |
| | 20a. Method of Disposition
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Moreland Memorial Cem. | | Date
5-30-96 | | 20c. Location - City or Town, State
Parkville, Maryland | |
| | 21. Signature of Funeral Service Licensee
Wallace S. Brooks, Jr. | | | | 22. Name and Address of Facility
Ruck Towson Funeral Home, Inc.
1050 York Road, Towson, Md. 21204 | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. Pneumonia
Due to (or as a consequence of):
b. Congestive Heart Failure
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | |
| | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown | | | | | | | |
| | 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | |
| 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one)
Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | |
| 27. Manner of Death
1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide
5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | |
| | | 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | |
| 29a. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | |
| 29b. Signature and title of certifier | | | | 29c. License number
812504 | | 29d. Date signed (Month, Day, Year)
5-28-96 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Eddie Nakhuda, M.D. 2300 Dulaney Valley Road, Towson, MD 21204 | | | | | | | | |
| 31. Date filed (Month, Day, Year)
MAY 30 1996 | | | | 32. Registrar's Signature
John A. Nakhuda | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 15910

| | | | | | | | | | | | | |
|-------------------------------------|--|--|--|--|--|--|--|--|---|--|-----------------------------------|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
WILLIAM HOWARD GERSTMYER | | | | | | 2. Date of Death
Month Day Year
MAY 29, 1996 | | 3. Time of Death
6:40 AM. | | | |
| | 4a. Facility Name (If not institution, give street and number)
2926 GUXTON AVE. | | | | | | 4b. City, Town, or Location of Death
FALLSTON | | 4c. County of Death
HARFORD | | | |
| Funeral
Director | 5. Social Security Number
212 05 7209 | | 8. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday)
84 Yrs. | | If Under 1 Year
Months Days | | If Under 24 Hrs.
Hours Min. | | | |
| | Usual Residence of Decedent | | 10a. State
MARYLAND | | 10b. County
BALTIMORE | | 10c. City, Town or Location
PARKVILLE | | 10d. Inside City Limits
1 <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | |
| To Be Completed by Funeral Director | 10e. Street and Number
3053 OAK FOREST DRIVE | | 10f. Zip Code
21234 | | 10g. Citizen of What Country?
U.S.A. | | 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | | |
| | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: WHITE | | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 11 YRS.
College (1-4or 5+) | | 16. Kind of Business/Industry
BALTIMORE
GAST ELECTRIC | | 17. Father's Name (First, Middle, Last)
WILLIAM HOWARD GERSTMYER | | | |
| | 18. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
BUYER | | 19. Informant's Name/Relationship (Type, Print)
H.T. TIMOTHY GERSTMYER | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
P.O. Box 557 FALLSTON, MARYLAND 21047 | | 20. Method of Disposition
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
ST. JOHN'S CEMETERY | | | |
| | 20c. Location - City or Town, State
JUN 21 1996
PARKVILLE, MARYLAND | | 21. Signature of Funeral Service Licensee
[Signature] | | 22. Name and Address of Facility
EVANS CHAPEL OF MEMORIES
8800 HARFORD ROAD - PARKVILLE | | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
LUNG CANCER | | Approximate Interval Between Onset and Death
5 months | | | |
| | 23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | 23c. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | |
| | 26. Place of Death (Check only one)
Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA
Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide
5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | |
| | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | 29a. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier
[Signature] | | 29c. License number
D47625 | | | |
| | 29d. Data signed (Month, Day, Year)
MAY 29, 1996 | | 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)
RICHARD A. O'MALLEY 660 KENILWORTH AVE TOWSON, MD 21204 | | 31. Date filed (Month, Day, Year)
MAY 30 1996 | | 32. Registrar's Signature
[Signature] | | 12 | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

96 15911

1 FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|---|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
Edward M. Gorschboth | | | | 2. DATE OF DEATH
MONTH DAY YEAR
MAY 28 th 1996 | | 3. TIME OF DEATH
3:00 A.M. | |
| 4. SOCIAL SECURITY NUMBER
217-03-8730 | | 5. SEX
1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | 6. AGE (In yrs. last birthday)
82 YRS. | 7. DATE OF BIRTH
(Month, Day, Year)
Nov. 25, 1913 | | 8. BIRTHPLACE (State or Foreign Country)
Maryland | |
| 9a. FACILITY NAME (If not institution, give street and number)
Union Memorial Hospital | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
Baltimore City | | 9c. COUNTY OF DEATH
N/A | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE
Md. | | 10b. COUNTY
N/A | | 10c. CITY, TOWN OR LOCATION
Baltimore City | | 10d. INSIDE CITY LIMITS?
1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER
4713 Greenhill Avenue | | | | 10f. ZIP CODE
21206 | | 10g. CITIZEN OF WHAT COUNTRY?
United States | |
| 11. MARITAL STATUS
1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify: White | |
| 15. DECEDENT'S EDUCATION
(Specify only highest grade completed)
Elementary/Secondary (0-12)
12 | | 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.)
Repairman | | 16b. KIND OF BUSINESS/INDUSTRY
BG&E | | | |
| 17. FATHER'S NAME (First, Middle, Last)
Edward Gorschboth | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Lena Baumgarten | | | |
| 19a. INFORMANT'S NAME (Type/Print)
Doris E. Gorschboth | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
4731 Greenhill Avenue Baltimore, Md. 21206 | | | |
| 20a. METHOD OF DISPOSITION
1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
Hilltop Service Corp. 5/30/96 | | 20c. LOCATION — City or Town, State
Towson Maryland | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
Milton J. Knight Jr.
<i>Milton J. Knight Jr.</i> | | | | 22. NAME AND ADDRESS OF FACILITY
Leonard J. Ruck, Inc.
5305 Harford Road Baltimore, Md. 21214 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. SEPSIS | | | | | | | |
| DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| b. CVA, D.M. | | | | | | | |
| DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| c. HTN, L.GIB. | | | | | | | |
| DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| d. | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
LUNG MASS, COPD, PROSTATE CA. | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | | | | |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | | | | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA
OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation
2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined
3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY
(Month, Day, Year) | | 28b. TIME OF INJURY
M | | 28c. INJURY AT WORK?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| | | 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. CERTIFIER (Check only one)
1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
<i>Siddiqi M.D.</i> | | | | 29c. LICENSE NUMBER
AT2438946 | | 29d. DATE SIGNED (Month, Day, Year)
MAY 28 th '96 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
N. SIDDIQI DEPT. MED. UMH: BALTIMORE 21218 | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
MAY 30 1996 | | | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 96 15912

Certificate of Death

Reg. No.

| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|--|--|---|--|---|--|--|--|---|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Richard Green | | | | 2. Date of Death
Month Day Year
May 28, 1996 | | 3. Time of Death
2:00 AM | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | 4a. Facility Name (If not institution, give street and number)
Maryland General Hospital | | | | 4b. City, Town, or Location of Death
Baltimore City | | 4c. County of Death
N/A | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Funeral
Director | 5. Social Security Number
251-12-3473 | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)
76 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth (Month, Day, Year)
Oct. 24, 1919 | 9. Birthplace (State or Foreign Country)
SC | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | Usual Residence of Decedent | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| To Be Completed by Funeral Director | 10a. State
MD | | 10b. County
n/a | | 10c. City, Town or Location
Baltimore | | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | 10e. Street and Number
2321 Rosedale St. | | | | 10f. Zip Code
21216 | | 10g. Citizen of What Country?
USA | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No
If Yes, Give Year or Dates: WWII | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: Black | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 8th
College (1-4 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Laborer | | 16b. Kind of Business/Industry
National Gypsum | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | 17. Father's Name (First, Middle, Last)
Sam Green | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Corine Thompson | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print)
Annie D. Green | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
2321 Rosedale St. BALto., MD 21216 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | 20a. Method of Disposition
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Garrison Forest | | 20c. Location - City or Town, State
6/2/96 Owings Mills, MD | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | 21. Signature of Funeral Service Licensee
 | | | | 22. Name and Address of Facility
James A. Morton & Sons Funeral Home
1701 Laurens St. BALto., MD 21217 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | <table border="0"> <tr> <td rowspan="4"> Immediate Cause (Final disease or condition resulting in death)

 Due to (or as a consequence of):
 Metastatic Cancer
 Colon Cancer
 Due to (or as a consequence of):
 Prostatic Cancer
 Due to (or as a consequence of):
 Due to (or as a consequence of): </td> <td colspan="7"></td> </tr> <tr><td colspan="7"></td></tr> <tr><td colspan="7"></td></tr> <tr><td colspan="7"></td></tr> </table> | | | | | | | | Immediate Cause (Final disease or condition resulting in death)

Due to (or as a consequence of):
Metastatic Cancer
Colon Cancer
Due to (or as a consequence of):
Prostatic Cancer
Due to (or as a consequence of):
Due to (or as a consequence of): | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Immediate Cause (Final disease or condition resulting in death)

Due to (or as a consequence of):
Metastatic Cancer
Colon Cancer
Due to (or as a consequence of):
Prostatic Cancer
Due to (or as a consequence of):
Due to (or as a consequence of): | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide
5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 29a. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier
 | | 29c. License number
89233 | | 29d. Date signed (Month, Day, Year)
May 28, 1996 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Arwimah Bautista, M.D. c/o Maryland General Hospital | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
MAY 30 1996 | | 32. Registrar's Signature
 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

10

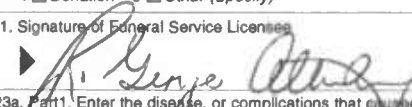
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 15913

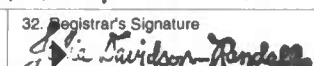
Certificate of Death

Reg. No.

| | | | | | | | | |
|---|--|--|---|--|--|---|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
MARY REGINA HOWARD | | | | 2. Date of Death
Month Day Year
May 28, 1996 | | 3. Time of Death
8:55PM | |
| | 4a. Facility Name (If not institution, give street and number)
Horizon Specialty Center | | | | 4b. City, Town, or Location of Death
Baltimore | | 4c. County of Death
N/A | |
| Funeral
Director | 5. Social Security Number
214-01-1388 | | 6. Sex
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday)
87 Yrs. | | 8. Date of Birth (Month, Day, Year)
May 5, 1909 | |
| | 9. Birthplace (State or Foreign Country)
Maryland | | 10a. State
MD | | 10b. County
N/A | | 10c. City, Town or Location
Baltimore | |
| To Be Completed by Funeral Director | 10d. Inside City Limits
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 10e. Street and Number
1300 S. Ellwood St. | | 10f. Zip Code
21224 | | 10g. Citizen of What Country?
USA | |
| | 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: White | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) Unknown
College (1-4 or 5+) College (1-4 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Secretary | | 16b. Kind of Business/Industry
Baltimore City | | | |
| | 17. Father's Name (First, Middle, Last)
John Joseph Callahan | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Mary Agnes McCormick | | | |
| | 19a. Informant's Name/Relationship (Type, Print)
Kenneth Gemundt | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
4267 44th St. Apt. 2, San Diego, CA 92115-4804 | | | |
| | 20a. Method of Disposition
1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Green Mount Crematory | | Date
5/30/96 | | 20c. Location - City or Town, State
Baltimore, MD | |
| | 21. Signature of Funeral Service Licensee
 | | | | 22. Name and Address of Facility
ALTENBURG FUNERAL HOME, P.A.
6009 Harford Rd., Baltimore, MD 21214 | | | |
| | 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. ACUTE ASPIRATION PNEUMONIA
Due to (or as a consequence of):
b. GASTRIC RETENTION WITH EMESIS
Due to (or as a consequence of):
c. ACUTE GASTRITIS
Due to (or as a consequence of):
d.

Approximate Interval Between Onset and Death
a. 3-4 HOURS
b. 2 DAY
c. 6-7 DAYS
d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
CEREBROVASCULAR INSUFFICIENCY
DEBILITATED STATE | | | | | | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | |
| | | | | | | | 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | |
| | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | |
| To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 23b-f show any injury or other traumatic event, the Medical Examiner must be notified at once. | 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| | 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation
2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined
3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| | 28d. Describe how injury occurred | | 28e. Piece of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| | 29a. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | |
| | 29b. Signature and title of certifier
Joseph D. Notarangelo M.D. | | | | 29c. License number
D07316 | | 29d. Date signed (Month, Day, Year)
MAY 30 - 1996 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
JOSEPH D. NOTARANGELO M.D. 301 ST. PAUL PLACE. BALTIMORE 21202 | | | | | | | | |
| 31. Date filed (Month, Day, Year)
MAY 30 1996 | | 32. Registrar's Signature
 | | | | | | |
| State Registrar | | | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 15914

Certificate of Death

Reg. No.

| | | | | | | | | |
|--|---|--|---------------------------------|---|---|---|---|---|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
DANIEL C. HAAS, Sr. | | | | 2. Date of Death
Month MAY Day 24 Year 1996 | | 3. Time of Death
1019A | |
| | 4a. Facility Name (If not institution, give street and number)
MERCY MEDICAL CENTER | | | | 4b. City, Town, or Location of Death
BALTIMORE | | 4c. County of Death
N/A | |
| Funeral
Director | 5. Social Security Number
216-24-9670 | | 6. Sex
1 M 2 F | 7. Age (In yrs. last birthday)
65 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth (Month, Day, Year)
Sept 14, 1930 | 9. Birthplace (State or Foreign Country)
Md |
| | Usual Residence of Decedent | | | | | | | |
| 10a. State
Md | | 10b. County
N/A | | 10c. City, Town or Location
Baltimore | | | 10d. Inside City Limits
1 Yes 2 No | |
| 10e. Street and Number
126 N. Potomac Street | | | | 10f. Zip Code
21224 | | 10g. Citizen of What Country?
USA | | |
| 11. Marital Status
1 Never Married 2 Married
3 Widowed 4 Divorced | | 12. Was Decedent Ever In U.S. Armed Forces?
1 Yes 2 No
If Yes, Give Year or Dates: 1948-49 | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 Yes 2 No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: White | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 9 College (1-4or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Mechanic | | 16b. Kind of Business/Industry
Steel | | |
| 17. Father's Name (First, Middle, Last)
George Haas | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Frances Wszolek | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
Dorothy Haas/ wife | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
126 N. Potomac Street, Balto, Md 21228 | | | | |
| 20a. Method of Disposition
1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Chesapeake Crematory | | Date
5/27/96 | | 20c. Location - City or Town, State
Beltsville, Md. | | |
| 21. Signature of Funeral Service Licensee
 | | | | 22. Name and Address of Facility
Moran-Ashton Funeral Home, Inc
3000 E. Baltimore Street, Balto, Md 21224 | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
Dr. Cavetay pneumonia

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
extensive pulmonary embolism
Cardiomegaly & atherosclerosis
ventricular dilatation | | | | | | | | Approximate Interval Between Onset and Death |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
PNEUMONIA
PULMONARY HEMORRHAGE | | | | | | | | 23b. Did tobacco use contribute to the cause of death?
1 Yes 2 No 3 Probably 4 Unknown |
| 24a. Was an autopsy performed?
1 Yes 2 No | | | | 24b. Were autopsy findings available prior to completion of cause of death?
1 Yes 2 No | | | | |
| 25. Was case referred to medical examiner?
1 Yes 2 No | | 26. Place of Death (Check only one)
Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) | | | | | | |
| 27. Manner of Death
1 Natural 5 Pending Investigation
2 Accident 6 Could not be determined
3 Suicide 4 Homicide | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
1 Yes 2 No | | 28d. Describe how injury occurred |
| 29a. Certifier (Check only one)
1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier
 | | 29c. License number
P09131 | | 29d. Date signed (Month, Day, Year)
MAY 24 1996 | | |
| 30. Name and address of person who completed cause of death (Item 29a) (Type, Print)
KEITH HAIRSTON 301 ST PAUL PL. | | | | | | | | |
| 31. Date filed (Month, Day, Year)
MAY 3 01996 | | | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 24a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

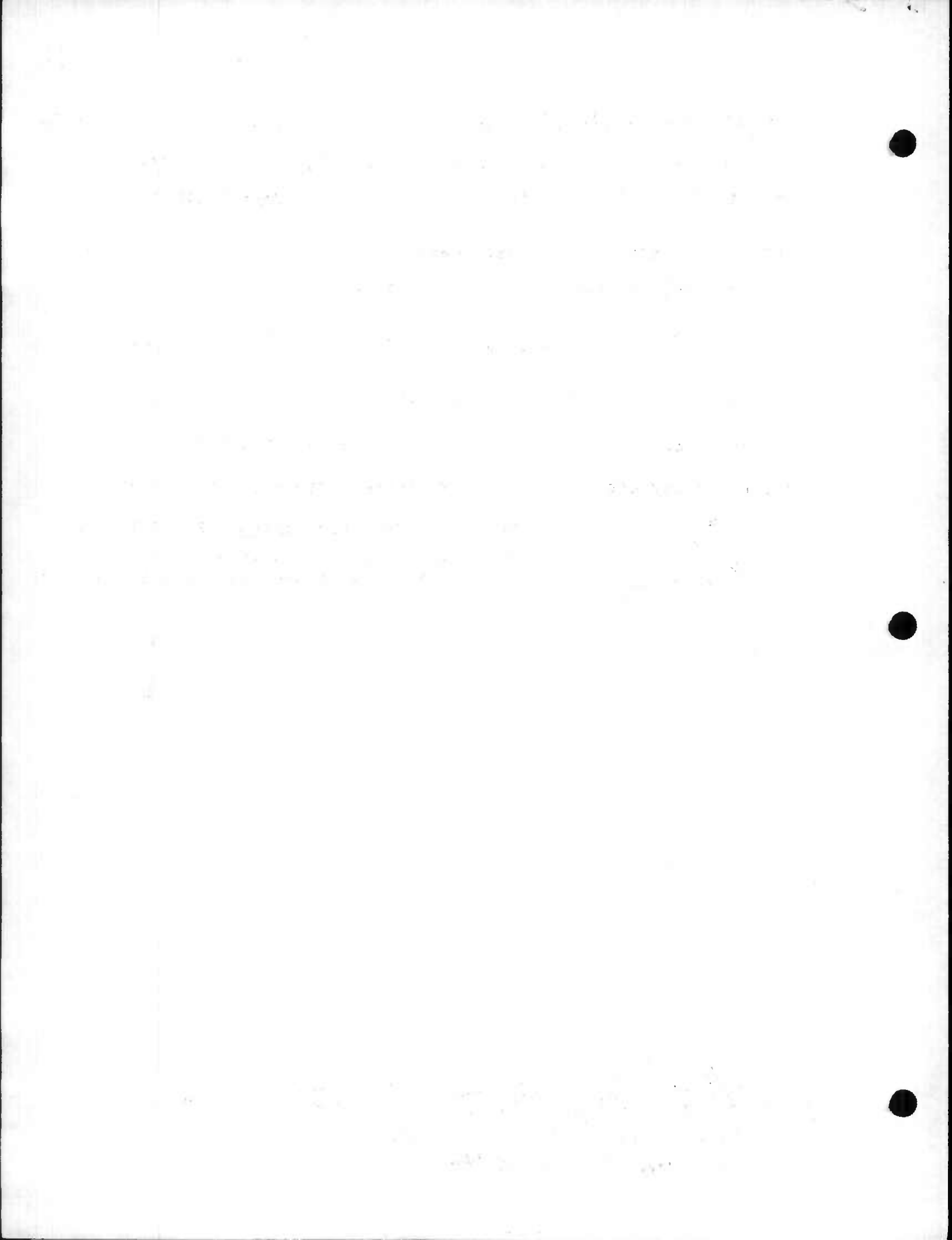
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Q

State
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 15915

Certificate of Death

Reg. No.

| | | | | | | | | |
|-------------------------------------|---|--|---|--|--|--|---|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
THELMA C JENKINS | | | | 2. Date of Death
Month Day Year
MAY 25, 1996 | | 3. Time of Death
20:34 P | |
| | 4a. Facility Name (If not institution, give street and number)
GOOD SAMARITAN ER | | | | 4b. City, Town, or Location of Death
BALTIMORE | | 4c. County of Death
N/A | |
| Funeral
Director | 5. Social Security Number
220-20-2643 | | 6. Sex
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday)
67 Yrs. | | 8. Date of Birth
Month Day Year
OCT 30, 1928 | |
| | 9. Birthplace (State or Foreign Country)
Maryland | | 10a. State
MD | | 10b. County
N/A | | 10c. City, Town or Location
BALTIMORE | |
| To Be Completed by Funeral Director | 10d. Inside City Limits
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 10e. Street and Number
823 E. COLDSRING LANE | | 10f. Zip Code
21212 | | 10g. Citizen of What Country?
U.S.A | |
| | 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: BLACK | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12th | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
POSTAL WORKER | | 16b. Kind of Business/Industry
POST OFFICE | | | |
| | 17. Father's Name (First, Middle, Last)
BIRLEY C. RICHARDSON | | 18. Mother's Name (First, Middle, Maiden Surname)
JULIA BRANNON | | 19a. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
7211 FAIRBROOK DR. WOODLAWN MD, 21224 | | 19b. Informant's Name/Relationship (Type, Print)
GERTRUDE LEE | |
| | 20a. Method of Disposition
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
KING MEADOW PK | | 20c. Location - City or Town, State
SPARKY RANDALL TOWN MD | | 21. Signature of Funeral Service Licensee
GARY T. MARSH FUNERAL HOME PA | |
| | 22. Name and Address of Funeral Home
270 FREDERICK PASS BALT. MD, 21229 | | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
Immediate Cause (Final disease or condition resulting in death)
a. RUPTURED MYOCARDIAL INFARCT
Due to (or as a consequence of):
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of): | | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | 24a. Was an autopsy performed?
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| | 24b. Were autopsy findings available prior to completion of cause of death?
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 25. Was case referred to medical examiner?
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> Outpatient 3 <input type="checkbox"/> DOA
Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | 27. Member of Death
1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide
5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | |
| | 28a. Date of Injury (Month, Day Year) | | 28b. Time of injury
M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | |
| | 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | 29a. Certifier (Check only one)
1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier
Mayte D. McShane MD | |
| | 29c. License number
OCME | | 29d. Date signed (Month, Day, Year)
MAY 26, 1996 | | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
WILSON S. KOREN 111 Penn Street, Baltimore, Maryland 21201 | | 31. Date filed (Month, Day, Year)
MAY 30 1996 | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 96 15916

Certificate of Death

Reg. No.

| | | | | | | | | | | | |
|--|--|-----------------------------------|---|---|--|---|--|--|---|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
OLLIE JACKSON | | | | | | 2. Date of Death
Month 5 / Day 24 / Year 96 | | 3. Time of Death
2:45 PM | | |
| | 4a. Facility Name (If not institution, give street and number)
(HOME) 507 N. FULTON AVE. | | | | | | 4b. City, Town, or Location of Death
BALTIMORE | | 4c. County of Death
BALTO. CITY | | |
| Funeral
Director | 5. Social Security Number
216 14 3358 | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday)
76 Yrs. | | 8. Date of Birth (Month, Day, Year)
5/8/20 | | 9. Birthplace (State or Foreign Country)
VIRGINIA | | |
| | Usual Residence of Decedent | | | | | | | | | | |
| 10a. State
MD. | | 10b. County
BALTO, CITY | | 10c. City, Town or Location
BALTIMORE | | | | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | |
| 10e. Street and Number
507 N. FULTON AVE. | | | | 10f. Zip Code
21223 | | 10g. Citizen of What Country?
USA | | | | | |
| 11. Marital Status
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc.
Specify: BLACK | | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (1-4or 5+) 0 | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
MEAT CUTTER | | | 16b. Kind of Business/Industry | | | | |
| 17. Father's Name (First, Middle, Last)
CLARENCE JACKSON | | | | | | 18. Mother's Name (First, Middle, Maiden Surname)
MARIA MONROE | | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
BLANCHE BETTIS | | | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
507 N. FULTON AVE. BALTO. MD. 21223 | | | | | |
| 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
MT. ZION 5/29/96 | | | 20c. Location - City or Town, State
Lansdowne, MD. | | | | | |
| 21. Signature of Funeral Service Licensee
<i>[Signature]</i> | | | | | | 22. Name and Address of Facility
ESTEP BROTHERS FUNERAL HOME P.A.
1300 EUTAW PL. BALTIMORE, MD. 21217 | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. Lung Cancer
Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | | | | Approximate Interval Between Onset and Death | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | |
| | | | | | | | | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | |
| | | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No | | | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accidental <input type="checkbox"/> Suicidal <input type="checkbox"/> Homicidal <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input type="checkbox"/> No | | 28d. Describe how injury occurred | | |
| | | | 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | | |
| 29b. Signature and title of certifier
<i>[Signature]</i> MD. | | | 29c. License number
D44810 | | | 29d. Date signed (Month, Day, Year)
5/24/96 | | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
LYNET B. JOHNSON 29 S. GREENE ST, SUITE 200, BALTIMORE MD 21201 | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
MAY 30 1996 | | | 32. Registrar's Signature
<i>[Signature]</i> | | | | | | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 15917

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

ROSETTA DEANS JOHNSON

2. Date of Death

May 23, 1996

3. Time of Death

2:30 a.m.

Funeral
Director

4a. Facility Name (If not institution, give street and number)

2312 AISQUITH STREET

4b. City, Town, or Location of Death

BALTIMORE, MD.

4c. County of Death

CITY

5. Social Security Number

243-46-8045

6. Sex

1 ☐ M ☒ F

7. Age (In yrs. last birthday)

67 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

May 10, 1929

9. Birthplace (State or Foreign Country)

N.C.

Usual Residence of Decedent

10a. State

MD.

10b. County

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

2312 AISQUITH STREET

10f. Zip Code

21218

10g. Citizen of What Country?

U.S.

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

SECRETARY

16b. Kind of Business/Industry

FEDERAL GOVERNMENT

17. Father's Name (First, Middle, Last)

LUTHER DEANS

18. Mother's Name (First, Middle, Maiden Surname)

HELEN JENKINS

19a. Informant's Name/Relationship (Type, Print)

MABLE STOKES

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2567 KIRK AVENUE

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

JERUSALEM CEMETERY

Date

5/29/96

20c. Location - City or Town, State

WOODLAND, N.C.

21. Signature of Funeral Service Licensee

Ronald A. Grayson

22. Name and Address of Facility

6243 3rd St., N.W. D.C.
TRI-STATE FUNERAL SERVICES, INC.

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Bronchoalveolar cell lung cancer

Approximate Interval Between Onset and Death

11 months

Due to (or as a consequence of):

Due to (or as a consequence of):

Due to (or as a consequence of):

Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☐ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending Investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

29b. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Peter White, Jr. MD

29c. License number

D36775

29d. Date signed (Month, Day, Year)

5-24-96

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Peter White, Jr MD Rutland Ave. Baltimore MD 21205

31. Date filed (Month, Day, Year)

MAY 30 1996

32. Registrar's Signature

J. H. Anderson-Randall

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 15918

Certificate of Death

Reg. No.

| | | | | | | | |
|--|--|--|---|---|--|---|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
BRENDA JOYCE JOHNSON | | | 2. Date of Death
Month May Day 26 , Year 1996 | | 3. Time of Death
7:58 pm | |
| | 4a. Facility Name (If not institution, give street and number)
804 Wicklow Road | | | 4b. City, Town, or Location of Death
Baltimore | | 4c. County of Death
n/a | |
| Funeral
Director | 5. Social Security Number
217-50-6093 | | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)
48 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth
(Month, Day, Year)
FEB. 4, 1948 |
| | 9. Birthplace (State or Foreign Country)
BALTIMORE, MD | | | | | | |
| To Be Completed by
Funeral Director | 10e. State
MD | | 10b. County
n/a | | 10c. City, Town or Location
BALTIMORE | | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |
| | 10e. Street and Number
2926 ROSALIND AVENUE | | | 10f. Zip Code
21215 | | 10g. Citizen of What Country?
UNITED STATES | |
| | 11. Marital Status
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: BLACK |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12th College (1-4 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
SECRETARY | | 16b. Kind of Business/Industry
BALTIMORE CITY HEALTH DEPT. | | |
| | 17. Father's Name (First, Middle, Last)
WILLIE HEMPHILL | | | 18. Mother's Name (First, Middle, Maiden Surname)
VIVA GREEN | | | |
| Physician
/Medical
Examiner | 19a. Informant's Name/Relationship (Type, Print)
DEBORAH HEMPHILL, VIVA | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
804 WICKLOW ROAD, BALTIMORE, MARYLAND | | | |
| | 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
WESTERN STAR CEMETERY | | Date
5-31 | | 20c. Location - City or Town, State
CATONSVILLE, MD |
| | 21. Signature of Funeral Service Licensee
<i>Bernard Johnson</i> | | | 22. Name and Address of Facility
March Funeral Home
1101 E. North Avenue, Baltimore, MD 21202 | | | |
| | 23e. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. End Stage Metastatic Carcinoma of Breast
Due to (or as a consequence of):
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last | | | | | | |
| | 23f. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Hypertensive Cardiovascular Disease | | | | | | |
| Medical Certification: To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | |
| | 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28d. Describe how injury occurred | | | | |
| | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | |
| | 29e. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | |
| State
Registrar | 29b. Signature and title of certifier
<i>Rifat Aboushy MD</i> | | | 29c. License number
D12729 | | 29d. Date signed (Month, Day, Year)
5/29/96 | |
| | 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)
Rifat Aboushy M.D. 2300 Garrison Blvd, Baltimore MD | | | | | | |
| 31. Date filed (Month, Day, Year)
MAY 30 1996 | | | 32. Registrar's Signature
<i>Gula Davidson-Randall</i> | | | | |

Baltimore, Maryland 21215-0020

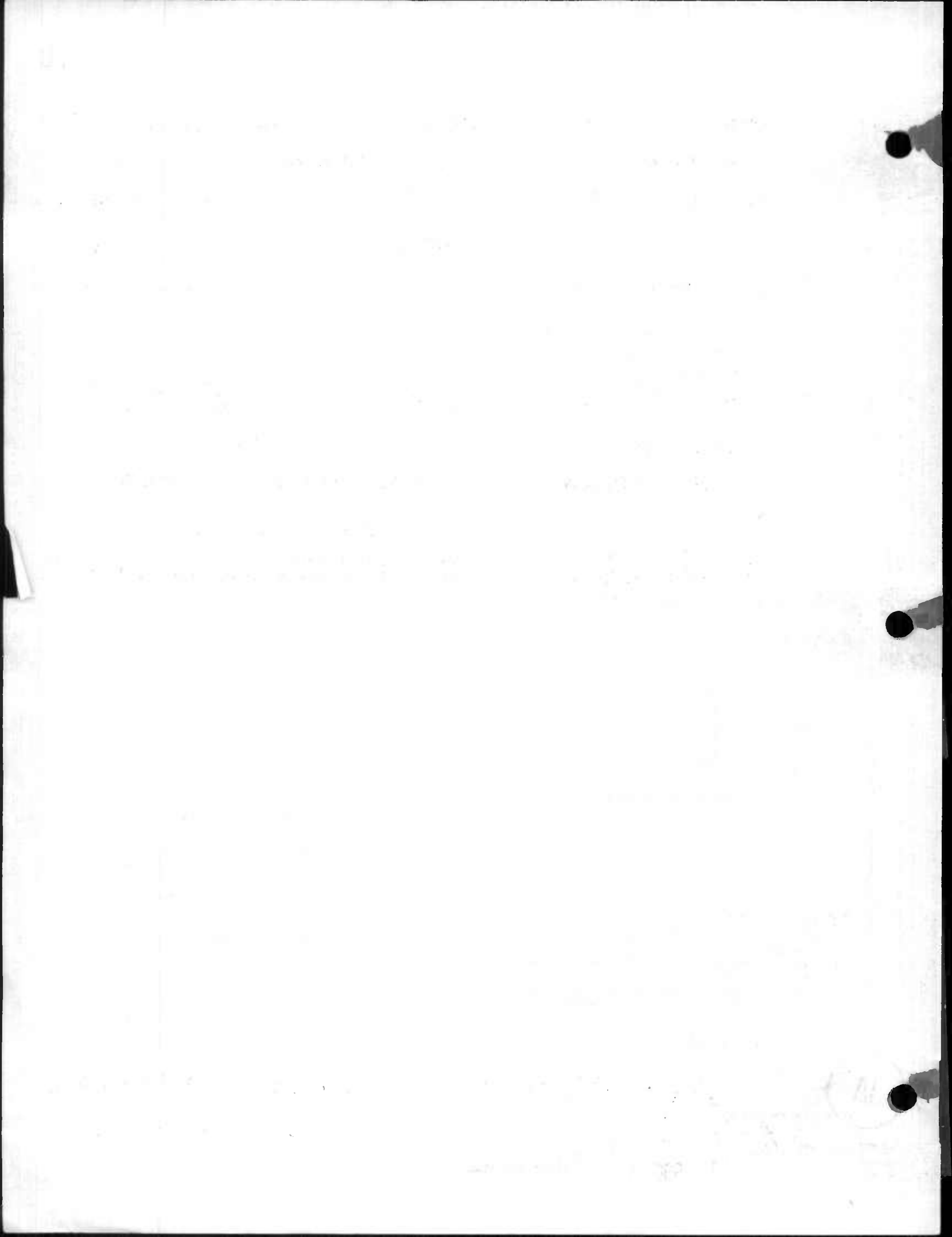
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



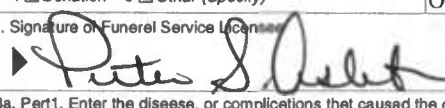
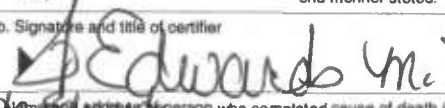
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 15919

Certificate of Death

Reg. No.

| | | | | | | | | |
|---|--|---|---|--|--|--|---|---|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Mildred G. Krout | | | | 2. Date of Death
Month Day Year
May 28, 1996 | | 3. Time of Death
10:45 P.M. | |
| | 4a. Facility Name (If not institution, give street end number)
Geneses-Heritage Elder Care-Center | | | | 4b. City, Town, or Location of Death
Dundalk | | 4c. County of Death
Baltimore | |
| Funeral
Director | 5. Social Security Number
218-12-3352 | | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (in yrs. last birthday)
84 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth (Month, Day, Year)
July 6, 1911 | 9. Birthplace (State or Foreign Country)
Maryland |
| | Usual Residence of Decedent | | | | | | | |
| To Be Completed by Funeral Director | 10a. State
Md. | 10b. County
Baltimore | 10c. City, Town or Location
Rosedale | | | 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| | 10e. Street end Number
2019 Summit Ave. | | | | 10f. Zip Code
21237 | | 10g. Citizen of What Country?
U.S.A. | |
| | 11. Marital Status
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: White | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 6th | | College (1-4or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Cafeteria Worker | | 16b. Kind of Business/Industry
Meat Plant | |
| | 17. Father's Name (First, Middle, Last)
Thomas S. Ashley | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Clara M. Sparwaser | | | |
| | 19a. Informant's Name/Relationship (Type, Print)
Shirley M. Carawan/Daughter | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
2019 Summit Ave., Baltimore, Md. 21237 | | | |
| | 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
OakLawn Cemetery | | Date
6-1-96 | | 20c. Location - City or Town, State
Baltimore, Md. | |
| | 21. Signature of Funeral Service Licensee
 | | | | 22. Name and Address of Facility
Bradley-Ashton Funeral Home, Inc.
2134 Willow Spring Rd., Balto., Md. 21222 | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | |
| | Immediate Cause (Final disease or condition resulting in death)
e. Atherosclerotic Cardiovascular disease 20 yrs
Due to (or as a consequence of):
b. Cardiac arrest
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Hx of psychosis 20y
Alzheimer's disease | | | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | |
| 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation
<input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined
<input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28d. Describe how Injury occurred | | | | |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | |
| 29b. Signature and title of certifier
 | | | | 29c. License number
DZ1696 | | 29d. Date signed (Month, Day, Year)
5/29/96 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Willard
1005 North Point Blvd, Ste 724 Balto, MD 21224 | | | | | | | | |
| 31. Date filed (Month, Day, Year)
MAY 3 01996 | | State Registrar | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

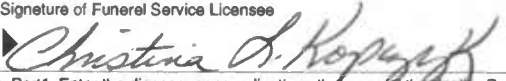
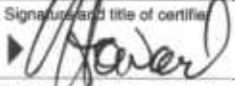
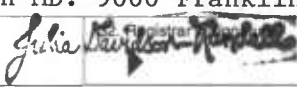
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 15920

Certificate of Death

Reg. No.

| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|---|--|---|--|--|--|--|---|---|---|--------------------------|--|--|--|--|--|--|--|--|--|--|--|--|----------------|---|--|--|--|--|--|------------------|----------------------------------|--|--|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Harry Pearce KLING | | | | 2. Date of Death
Month May Day 27 Year 1996 | | 3. Time of Death
4:50 pm. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | 4e. Facility Name (If not institution, give street and number)
FRANKLIN SQUARE HOSPITAL | | | | 4b. City, Town, or Location of Death
ROSEDALE | | 4c. County of Death
Baltimore County | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Funeral
Director | 5. Social Security Number
061-14-7259 | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)
78 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth (Month, Day, Year)
12/23/17 | 9. Birthplace (State or Foreign Country)
NEW YORK | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | Usual Residence of Decedent | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| To Be Completed by Funeral Director | 10a. State
MARYLAND | 10b. County
BALTIMORE | 10c. City, Town or Location
GLEN ARM | | | 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | 10e. Street and Number
11401 MANOR ROAD | | | | 10f. Zip Code
21057 | | 10g. Citizen of What Country?
USA | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | 11. Marital Status
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
If Yes, Give Year or Dates: WW II | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: WHITE | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) College (1-4 or 5+)
8 YEARS | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
SCIENTIST | | 16b. Kind of Business/Industry
PRIVATE SECTOR | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | 17. Father's Name (First, Middle, Last)
FRANK KLING | | | | 18. Mother's Name (First, Middle, Maiden Surname)
RHODA PEARCE | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | 19a. Informant's Name/Relationship (Type, Print)
HELEN KLING WIFE | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
11401 MANOR ROAD GLEN ARM, MD 21057 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | 20a. Method of Disposition
<input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
METRO CREMATORY, INC. | | Date
5/31/96 | 20c. Location - City or Town, State
CATONSVILLE, MD | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | 21. Signature of Funeral Service Licensee
 | | | | 22. Name and Address of Facility
JOHNSON FUNERAL HOME
8521 LOCH RAVEN BLVD. TOWSON, MD 21286 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | <table border="1"> <tr> <td rowspan="4">Immediate Cause (Final disease or condition resulting in death)</td> <td colspan="6">Cerebrovascular Accident</td> <td>Approximate Interval Between Onset and Death
3 weeks</td> </tr> <tr> <td colspan="6">Due to (or as a consequence of):
Aspiration Pneumonia</td> <td>3 weeks</td> </tr> <tr> <td colspan="6">Due to (or as a consequence of):
Renal Failure</td> <td>12 months</td> </tr> <tr> <td colspan="6">Due to (or as a consequence of):</td> <td></td> </tr> </table> | | | | | | | | Immediate Cause (Final disease or condition resulting in death) | Cerebrovascular Accident | | | | | | Approximate Interval Between Onset and Death
3 weeks | Due to (or as a consequence of):
Aspiration Pneumonia | | | | | | 3 weeks | Due to (or as a consequence of):
Renal Failure | | | | | | 12 months | Due to (or as a consequence of): | | | | | |
| Immediate Cause (Final disease or condition resulting in death) | Cerebrovascular Accident | | | | | | Approximate Interval Between Onset and Death
3 weeks | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | Due to (or as a consequence of):
Aspiration Pneumonia | | | | | | 3 weeks | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | Due to (or as a consequence of):
Renal Failure | | | | | | 12 months | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | Due to (or as a consequence of): | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation
<input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined
<input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 29b. Signature and title of certifier
 | | | | 29c. License number
D38048. | | 29d. Date signed (Month, Day, Year)
5/28/96. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Howard Goldman MD. 9000 Franklin Square Drive, Baltimore, Maryland 21237 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
MAY 30 1996
 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 15921

Certificate of Death

Reg. No.

| | | | | | | | | | |
|--|---|---|--|--------------------------------------|--|--|---|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Francis Edward Lemmon | | | | 2. Date of Death
Month Day Year
May 28 1996 | | 3. Time of Death
8:27 AM | | |
| | 4a. Facility Name (If not institution, give street and number)
1730 Edgewood Rd. | | | | 4b. City, Town, or Location of Death
Baltimore | | 4c. County of Death
Baltimore | | |
| Funeral
Director | 5. Social Security Number
218-05-7678 | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)
75 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth (Month, Day, Year)
Jan. 29 1921 | | 9. Birthplace (State or Foreign Country)
Maryland | |
| | Usual Residence of Decedent | | | | | | | | |
| To Be Completed by Funeral Director | 10a. State
Maryland | 10b. County
Baltimore | 10c. City, Town or Location
Baltimore | | | 10d. Inside City Limits
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | |
| | 10e. Street and Number
1730 Edgewood Rd. | | | 10f. Zip Code
21234 | | 10g. Citizen of What Country?
USA | | | |
| | 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No
If Yes, Give Year or Dates: WW II | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: White | | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (1-4or 5+) n/a | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Salesman | | | 16b. Kind of Business/Industry
Wholesale Liquor | | | |
| | 17. Father's Name (First, Middle, Last)
Francis Edward Lemmon | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Frances McGuire | | | | |
| | 19a. Informant's Name/Relationship (Type, Print)
Mrs. Frank Lemmon | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1730 Edgewood Rd., Balto., MD 21234 | | | | |
| | 20a. Method of Disposition
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
New Cathedral Cem. | | Date
5/31/96 | | 20c. Location - City or Town, State
Balto., MD | | |
| | 21. Signature of Funeral Service Licensee
<i>Lowell M. Lemmon</i>
Lowell M. Lemmon | | | | 22. Name and Address of Facility
Lemmon Funeral Home of Dulaney Valley, Inc.
10 W. Padonia Rd., Timonium, MD 21093 | | | | |
| | 23a. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | | Approximate Interval Between Onset and Death |
| | Immediate Cause (Final disease or condition resulting in death)
a. METASTATIC CANCER, LUNG PRIMARY
Due to (or as a consequence of): SUSPECTED NOT PROVED | | | | | | | | 6 mos. |
| b. Due to (or as a consequence of): | | | | | | | | | |
| c. Due to (or as a consequence of): | | | | | | | | | |
| d. Due to (or as a consequence of): | | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | |
| 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide
5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | |
| | | 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | |
| 29b. Signature and title of certifier
<i>John G. Lavin</i>
John G. Lavin M.D. | | | | 29c. License number
D20795 | | 29d. Date signed (Month, Day, Year)
5-30-96 | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
John G. Lavin M.D.
660 Kenilworth Dr., Suite 202, Towson, MD 21204 | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
MAY 30 1996 | | | | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

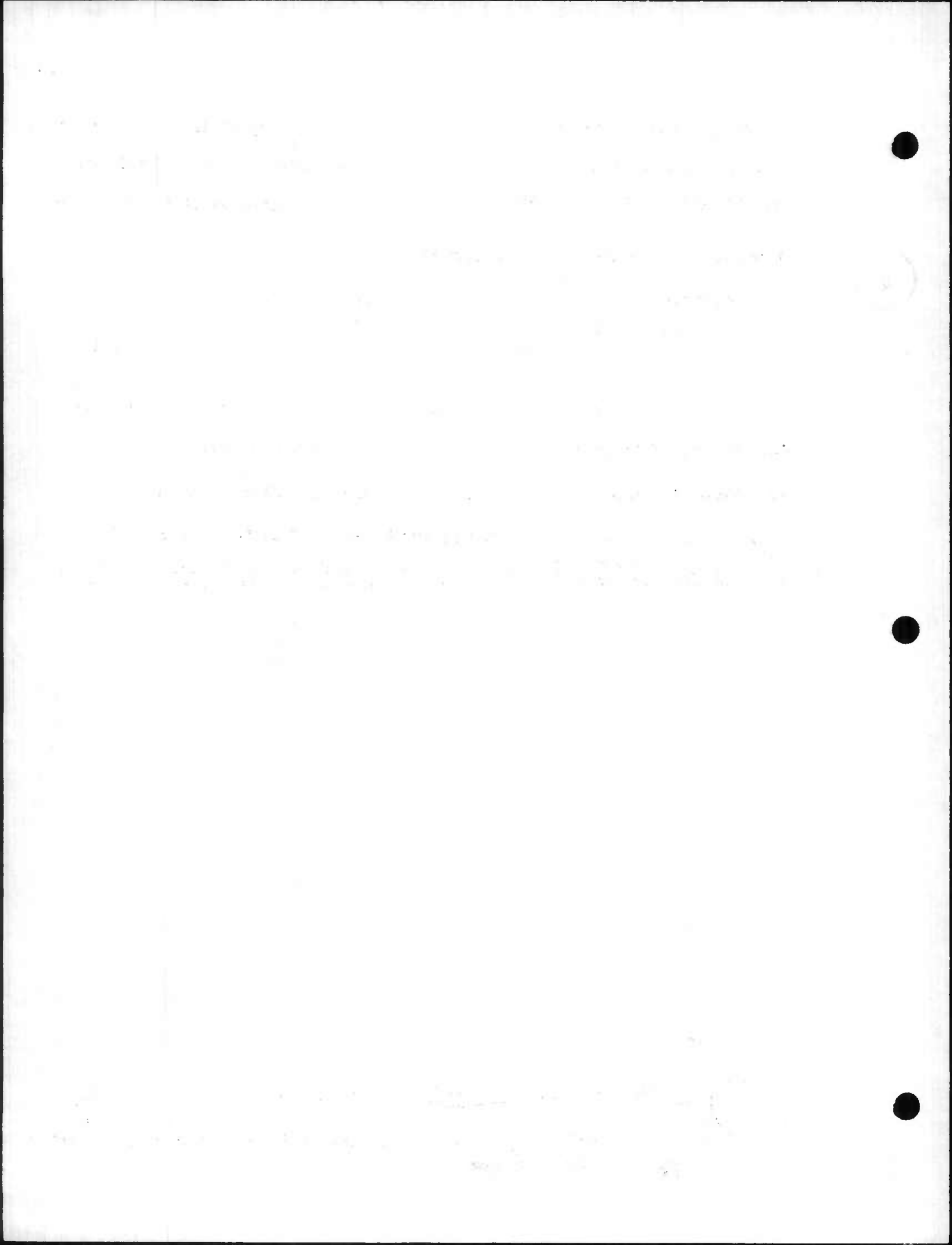
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 15922

Certificate of Death

Reg. No.

| | | | | | |
|---|---|---|--|--|---|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
MICHAEL LEWIS | | 2. Date of Death
Month Day Year
MAY 23, 1996 | | 3. Time of Death
2303PM |
| | 4a. Facility Name (If not institution, give street and number)
UNIVERSITY HOSPITAL S.T.U. | | 4b. City, Town, or Location of Death
BALTIMORE CITY | | 4c. County of Death
N/A |
| Funeral
Director | 5. Social Security Number
220-84-7589 | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)
27 | 8. Date of Birth (Month, Day, Year)
12-19-68 | 9. Birthplace (State or Foreign Country)
NY |
| | Usual Residence of Decedent | | | | |
| To Be Completed by Funeral Director | 10a. State
MD | 10b. County
Baltimore | 10c. City, Town or Location
Baltimore | | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |
| | 10e. Street and Number
1206 North Potomac Street | | 10f. Zip Code
21213 | | 10g. Citizen of What Country?
U.S. |
| | 11. Marital Status
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: Black |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 grade
College (1-4or 5+) | | 16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Clerk | | 16b. Kind of Business/Industry
Fed. Government |
| To Be Completed by Physician/Medical Examiner | 17. Father's Name (First, Middle, Last)
Gregory Curtis | | 18. Mother's Name (First, Middle, Maiden Surname)
Belinda Lewis | | |
| | 19a. Informant's Name/Relationship (Type, Print)
Jackie Lewis/Belinda Lewis | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1206 North Potomac Street Balt. Md 21213 | | |
| | 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Baltimore Cemetery | | 20c. Location - City or Town, State
5/30/96 Baltimore, MD |
| | 21. Signature of Funeral Service Licensee
Ronald A. Grayson | | 22. Name and Address of Facility
6234 3rd St., N.W. Wash.D.C. TRI-STATE FUNERAL SERVICES, INC. | | |
| Physician
/Medical
Examiner | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. Gunshot Wounds of Back and Right Arm
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. | | | | Approximate Interval Between Onset and Death |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |
| | 24a. Was an autopsy performed?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | 24b. Were autopsy findings available prior to completion of cause of death?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |
| | 25. Was case referred to medical examiner?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | |
| To Be Completed by Physician/Medical Examiner | 27. Manner of Death
<input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year)
5/23/96 | | 28b. Time of Injury
2230 M |
| | 28a. Place of Injury - At home, farm, street, tectory, office building, etc. (Specify)
Street | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred
Subject shot |
| | 29a. Certifier (Check only one)
<input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29c. License number
O.C.M.E. | | 29d. Date signed (Month, Day, Year)
MAY 24, 1996 |
| | 29b. Signature and Title of certifier
Theodore H. King | | | | |
| State Registrar | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
THEODORE M. KING 111 Penn Street, Baltimore, Maryland 21201 | | | | |
| | 31. Date filed (Month, Day, Year)
MAY 30 1996 | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 15923

Certificate of Death

Reg. No.

| | | | | | | | | | | | | | | | | | |
|--|--|---|---|---|---|--|---|--|---|--|---|--|---|-------------------|--|-------------------|----------|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
<u>Ruth E. Matthews</u> | | | | 2. Date of Death
Month <u>May</u> Day <u>24</u> Year <u>1996</u> | | 3. Time of Death
<u>8:59 AM</u> | | | | | | | | | | |
| | 4a. Facility Name (If not institution, give street and number)
<u>Faulston General Hospital</u> | | | | 4b. City, Town, or Location of Death
<u>Faulston</u> | | 4c. County of Death
<u>HARFORD</u> | | | | | | | | | | |
| Funeral
Director | 5. Social Security Number
<u>579-18-9750</u> | 6. Sex
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)
<u>80</u> Yrs. | If Under 1 Year
Months | If Under 24 Hrs.
Hours | 8. Date of Birth
(Month, Day, Year)
<u>SEPT 30, 1915</u> | 9. Birthplace (State or Foreign Country)
<u>WASHINGTON D.C.</u> | | | | | | | | | | |
| | Usual Residence of Decedent | | | | | | | | | | | | | | | | |
| To Be Completed by Funeral Director | 10a. State
<u>MARYLAND</u> | 10b. County
<u>HARFORD</u> | 10c. City, Town or Location
<u>ABINGDON</u> | | | 10d. Inside City Limits
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | | | | | |
| | 10e. Street and Number
<u>228 LAURENTUM PKWY.</u> | | | | 10f. Zip Code
<u>21009</u> | | 10g. Citizen of What Country?
<u>U.S.A.</u> | | | | | | | | | | |
| | 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: <u>WHITE</u> | | | | | | | | | | |
| | 15. Decedent's Education
(Specify only highest grade completed)
Elementary/Secondary (0-12) <u>12/YR.</u> College (1-4 or 5+) | | 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)
<u>CLERK</u> | | | 16b. Kind of Business/Industry
<u>FEDERAL GOV'T.</u> | | | | | | | | | | | |
| | 17. Father's Name (First, Middle, Last)
<u>ROYDEN JAMES DIXON</u> | | | | 18. Mother's Name (First, Middle, Maiden Surname)
<u>MARY CELILIA HUTCHINS</u> | | | | | | | | | | | | |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print)
<u>J. PAUL MATTHEWS</u> | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
<u>228 LAURENTUM PKWY. ABINGDON, MARYLAND 21009</u> | | | | | | | | | | | | |
| | 20a. Method of Disposition
1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
<u>GREEN MOUNT CEMETERY</u> | | 20c. Location - City or Town, State
<u>BALTIMORE, MARYLAND</u> | | 20d. Date of Disposition
<u>MAY 25, 1996</u> | | | | | | | | | | |
| | 21. Signature of Funeral Service Licensee
<u>[Signature]</u> | | | | 22. Name and Address of Facility
<u>EVANS FUNERAL CHAPEL - BELAIR, P.A. 21050</u>
<u>3 NEWPORT DRIVE FOREST HILL, MARYLAND</u> | | | | | | | | | | | | |
| | 23a. Pert I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | | | | | | | | | | |
| | <table border="0"> <tr> <td>Immediate Cause (Final disease or condition resulting in death)</td> <td>a. <u>Congestive Heart Failure</u>
Due to (or as a consequence of):</td> <td>Approximate Interval Between Onset and Death
<u>Eight days</u></td> </tr> <tr> <td rowspan="3">Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last</td> <td>b. <u>Myocardial Infarction</u>
Due to (or as a consequence of):</td> <td><u>Eight days</u></td> </tr> <tr> <td>c. <u>Ischemic Heart disease</u>
Due to (or as a consequence of):</td> <td><u>Ten years.</u></td> </tr> <tr> <td>d. _____</td> <td></td> </tr> </table> | | | | | | | | Immediate Cause (Final disease or condition resulting in death) | a. <u>Congestive Heart Failure</u>
Due to (or as a consequence of): | Approximate Interval Between Onset and Death
<u>Eight days</u> | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. <u>Myocardial Infarction</u>
Due to (or as a consequence of): | <u>Eight days</u> | c. <u>Ischemic Heart disease</u>
Due to (or as a consequence of): | <u>Ten years.</u> | d. _____ |
| Immediate Cause (Final disease or condition resulting in death) | a. <u>Congestive Heart Failure</u>
Due to (or as a consequence of): | Approximate Interval Between Onset and Death
<u>Eight days</u> | | | | | | | | | | | | | | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. <u>Myocardial Infarction</u>
Due to (or as a consequence of): | <u>Eight days</u> | | | | | | | | | | | | | | | |
| | c. <u>Ischemic Heart disease</u>
Due to (or as a consequence of): | <u>Ten years.</u> | | | | | | | | | | | | | | | |
| | d. _____ | | | | | | | | | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown | | | | | | | | | | | |
| | | | | | | 24e. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | | | | | |
| | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | | | | | |
| 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | | | | | | | | | |
| 27. Manner of Death
1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide
5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | | | | | | | |
| | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28d. Describe how injury occurred | | | | | | | | | | | | | |
| 29e. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier
<u>[Signature]</u> | | 29c. License number
<u>135522</u> | | 29d. Date signed (Month, Day, Year)
<u>May 24, 1996</u> | | | | | | | | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
<u>Mark Wild 2 North Avenue Bel Air Maryland 21014</u> | | | | | | | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
<u>MAY 30 1996</u> | | | | 32. Registrar's Signature
<u>[Signature]</u> | | | | | | | | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b-f show any injury or other traumatic event, the Medical Examiner must be notified at 202-54-0024.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Film G735 item 18 per FH 5-30-96 rja

Certificate of Death

Reg. No.

96 15924

| | | | | | | | | |
|---|--|---|--|---|---|---|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Louise Minnie Martin | | | | 2. Date of Death
Month May Day 26 Year 1996 | | 3. Time of Death
8:30 AM | |
| | 4a. Facility Name (If not institution, give street and number)
9 G Beehive Place | | | | 4b. City, Town, or Location of Death
Cockeysville | | 4c. County of Death
BALTIMORE | |
| Funeral
Director | 5. Social Security Number
219-03-2161 | | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday)
81 Yrs. | | 8. Date of Birth (Month, Day, Year)
Oct. 1, 1914 | |
| | 9. Birthplace (State or Foreign Country)
Balto. City, MD | | 10. Usual Residence of Decedent
10a. State MARYLAND 10b. County BALTIMORE 10c. City, Town or Location COCKEYSVILLE 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 11. Street and Number
9 G Beehive Place | | 12. Zip Code
21030 | |
| 13. Marital Status
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 14. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 15. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 16. Race - American Indian, Black, White, etc.
Specify: WHITE | | |
| 17. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 8 College (13-16) n/a | | 18. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Piece Worker | | 19. Kind of Business/Industry
Clothing | | 20. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Piece Worker | | |
| 21. Father's Name (First, Middle, Last)
Louis Reed | | | | 22. Mother's Name (First, Middle, Maiden Surname)
Christin (unknown by informant) | | | | |
| 23. Informant's Name/Relationship (Type, Print)
William C. Martin | | | | 24. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
9 G Beehive Place, Cockeysville, MD 21030 | | | | |
| 25. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 26. Place of Disposition (Name of cemetery, crematory or other place)
Dulaney Valley Mem. Gardens | | 27. Date
30 MAY | | 28. Location - City or Town, State
Timonium, MD | | |
| 29. Signature of Funeral Home Licensed
Bryan W. Clary | | 30. Name and Address of Facility
Lemmon Funeral Home of Dulaney Valley, Inc.,
10 W. Padonia Rd. Timonium, MD 21093 | | 31. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
Hypoxemia
Due to (or as a consequence of):
Chronic obstructive Pulmonary Disease 10 yrs | | 32. Approximate Interval Between Onset and Death
6 month | | |
| 33. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | 34. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | |
| 35. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 36. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No | | | | |
| 37. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 38. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | 39. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | 40. Date of Injury (Month, Day, Year)
5/28/96 | | |
| 41. Time of Injury
M | | 42. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 43. Describe how Injury occurred | | 44. Location (Street and Number or Rural Route Number, City or Town, State) | | |
| 45. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 46. Signature and title of certifier
W. Anthony Riley | | 47. License number
D25205 | | 48. Date signed (Month, Day, Year)
5/28/96 | | |
| 49. Name and address of person who completed cause of death (Item 23e) (Type, Print)
W. Anthony Riley, M.D., 6565 N. Charles St., (E. Pav. - Suite 203) 21204 | | 50. Date filed (Month, Day, Year)
MAY 30 1996 | | 51. Registrar's Signature
J. Davidson | | 52. State Registrar | | |

Baltimore, Maryland 21215-0020
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

96 15925

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|--|---|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last)
Ross E. McCauley | | | | 2. DATE OF DEATH
MONTH DAY YEAR
May 15 1996 | | 3. TIME OF DEATH
8:00AM M | |
| 4. SOCIAL SECURITY NUMBER
187-32-6944 | | 5. SEX
1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
90 YRS. | | 7. DATE OF BIRTH
(Month, Day, Year)
July 6, 1905 | |
| 9a. FACILITY NAME (If not institution, give street and number)
CALVERT Manor Nursing Home | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
CALVERT | | 9c. COUNTY OF DEATH
CECIL | |
| 10a. STATE
PENNA | | 10b. COUNTY
LANCASTER | | 10c. CITY, TOWN OR LOCATION
Drumore Twp. Quarryville | | 10d. INSIDE CITY LIMITS?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 10e. STREET AND NUMBER
1211 Slate Hill Road | | | | 10f. ZIP CODE
17566 | | 10g. CITIZEN OF WHAT COUNTRY?
USA | |
| 11. MARITAL STATUS
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify:
white | |
| 15. DECEDENT'S EDUCATION
(Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (1-4 or 5+) 12 | | 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.)
FARMER | | 16b. KIND OF BUSINESS/INDUSTRY
FARMING | | | |
| 17. FATHER'S NAME (First, Middle, Last)
Charles McCauley | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Margaret Hawk | | | |
| 19a. INFORMANT'S NAME (Type/Print)
R. DELMAR McCauley | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1213 SLATE HILL RD. QUARRYVILLE PA. 17566 | | | |
| 20a. METHOD OF DISPOSITION
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
Quarryville Cemetery 5/17 | | 20c. LOCATION — City or Town, State
Quarryville, PA. | | 20d. DATE
5/17 | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
 | | | | 22. NAME AND ADDRESS OF FACILITY
Reynolds Funeral Home - Quarryville, PA. 17566 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. CHF
b. CARDIOMYOPATHY + ARRHYTHMIA
c. HYPERTENSIVE CORONARY ARTERY DIS.
d.
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST | | | | | | | Approximate Interval Between Onset and Death
2 wks
2 yrs
10 yrs |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | 24a. WAS AN AUTOPSY PERFORMED?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/> | | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA
OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation
2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined
3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY
(Month, Day, Year) | | 28b. TIME OF INJURY
M | | 28c. INJURY AT WORK?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | 28g. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one)
1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
Dudley Phillips MD | | | | 29c. LICENSE NUMBER
D09482 | | 29d. DATE SIGNED (Month, Day, Year)
5/15/96 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
Dudley Phillips MD, DARTINGTON, MD 21034 | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
MAY 30 1996 | | | | 32. REGISTRAR'S SIGNATURE
 | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. The first part of the paper is devoted to a discussion of the general principles of the theory of the structure of the atom. It is shown that the structure of the atom is determined by the laws of quantum mechanics, which are based on the principle of the uncertainty of the position and momentum of the particles.

2. In the second part of the paper, the author discusses the problem of the structure of the nucleus. It is shown that the structure of the nucleus is determined by the laws of quantum mechanics, which are based on the principle of the uncertainty of the position and momentum of the particles.

3. In the third part of the paper, the author discusses the problem of the structure of the molecule. It is shown that the structure of the molecule is determined by the laws of quantum mechanics, which are based on the principle of the uncertainty of the position and momentum of the particles.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 15926

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

RAYMOND P. MAZZA

2. Date of Death

Month
MAYDay
25, 1996

3. Time of Death

8:00AM

4a. Facility Name (If not institution, give street and number)

GREATER BALTIMORE MEDICAL CENTER

4b. City, Town, or Location of Death

TOWSON

4c. County of Death

BALTIMORE

Funeral
Director

5. Social Security Number

162-22-5645

6. Sex

☒ M ☐ F

7. Age (in yrs. last birthday)

67

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)
DECEMBER 4, 1928

9. Birthplace (State or Foreign Country)

HARRISBURG, PA.

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

BALTIMORE

10c. City, Town or Location

BALTIMORE COUNTY

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

6528 LANGDALE ROAD

10f. Zip Code

21237

10g. Citizen of What Country?

U.S.A.

11. Marital Status

☐ Never Married ☒ Married☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

☒ Yes ☐ No

If Yes, Give

Year or Dates: KOREA

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify:

WHITE

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

4

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

SCHOOL TEACHER

16b. Kind of Business/Industry

BALTIMORE COUNTY BOARD OF
EDUCATION

17. Father's Name (First, Middle, Last)

GIACOMINA MARIO MAZZA

18. Mother's Name (First, Middle, Maiden Surname)

THERESA MARIE CERZULLO

19a. Informant's Name/Relationship (Type, Print)

LENA M. MAZZA (WIFE)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

6528 LANGDALE ROAD BALTIMORE, MARYLAND 21237

20a. Method of Disposition

☐ Burial ☐ Cremation ☐ Removal from State☐ Donation ☒ Other (Specify) ENTOMBMENT

20b. Place of Disposition (Name of

cemetery, crematory or other place)

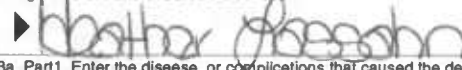
GARDENS OF FAITH CEMETERY MAY 29, 1996

Data

20c. Location - City or Town, State

BALTIMORE, MARYLAND

21. Signature of Funeral Service Licensee



22. Name and Address of Facility

LASSAUN FUNERAL HOME, INC.
7401 BELAIR ROAD BALTIMORE, MARYLAND 21236-4625

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate
Interval Between
Onset and DeathImmediate Cause (Final
disease or condition
resulting in death)

a. SEPSIS

Due to (or as a consequence of):

b. HEPATOCELLULAR CANCER

Due to (or as a consequence of):

Sequently list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

DEHYDRATION, RENAL FAILURE

LARYNGEAL CANCER

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown24a. Was an autopsy
performed?☐ Yes ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?☐ Yes ☐ No25. Was case referred to medical
examiner?☐ Yes ☒ No

Hospital:

☒ Inpatient☐ ER/Outpatient☐ DOA

26. Place of Death (Check only one)

Other:

☐ Nursing Home☐ Residence☐ Other (Specify)

27. Manner of Death

☒ Natural☐ Accident☐ Suicide☐ Homicide☐ Pending
Investigation☐ Could not be
determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of
Injury

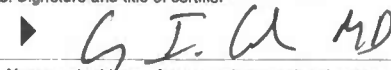
M

28c. Injury et
Work?☐ Yes ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier



29c. License number

D27730

29d. Date signed (Month, Day, Year)

5/25/96

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

GARY COHEN, MD 6569 N. CHARLES ST. BALTO MD 21204

31. Date filed (Month, Day, Year)

MAY 30 1996

32. Registrar's Signature



Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.

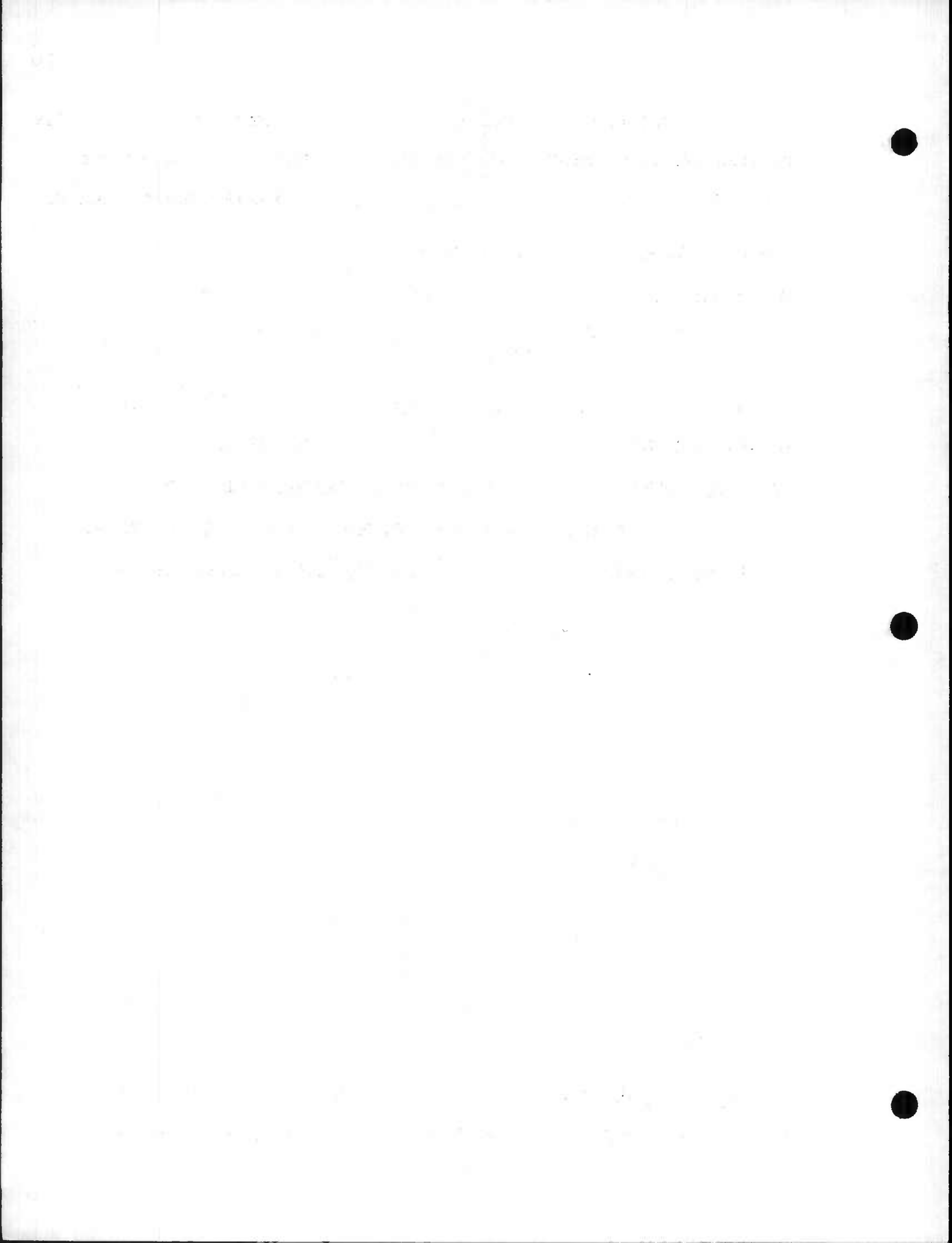
Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: This certificate has been signed by the attending physician and
completely filled in by the funeral director. page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

State
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 15927

File# 6736 item 8 per FH 6-20-96 rja

Certificate of Death

Reg. No.

| | | | | | | | | | | | |
|---|---|--|---|--|--|--|---|---|---|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Edward Alexander Marecki | | | | | | 2. Date of Death
Month May Day 28 Year 1996 | | 3. Time of Death
659 A | | |
| | 4a. Facility Name (If not institution, give street and number)
Mercy Medical Center | | | | | | 4b. City, Town, or Location of Death
Baltimore | | 4c. County of Death
NA | | |
| Funeral
Director | 5. Social Security Number
217-05-6671 | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday)
80 Yrs. | | 8. Date of Birth (Month, Day, Year)
Jan. 1 1916 | | 9. Birthplace (State or Foreign Country)
Maryland | | |
| | Usual Residence of Decedent | | | | | | 10a. State
Maryland | | 10b. County
Baltimore | | 10c. City, Town or Location
Rosedale |
| 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | 10e. Street and Number
Chesaco Ave. 1315 Apt. 124 | | 10f. Zip Code
21237-1548 | | 10g. Citizen of What Country?
U.S.A. | |
| 11. Marital Status
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | | 12. Was Decedent Ever in U.S. Armed Forces?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
If Yes, Give Year or Dates: 3/29/45
2/4/46 | | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc.
Specify: White | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 11 College (1-4or 5+) NA | | | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Proprietor | | | 16b. Kind of Business/Industry
Bakery | | |
| 17. Father's Name (First, Middle, Last)
Alexander Marecki | | | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Ida Pakulski | | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
Marie Marecki / Wife | | | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Chesaco Ave. 1315 Apt. 124 | | | | | |
| 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Gardens of Faith | | | Date
May 31 | | 20c. Location - City or Town, State
Baltimore, Maryland | | | |
| 21. Signature of Funeral Service Licensee
 | | | | | | 22. Name and Address of Facility
W. Dabrowski/Chojnacki F.H. P.A.
1005 Dundalk Ave. Balt., MD. 21224 | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | | | | Approximate Interval Between Onset and Death | |
| Immediate Cause (Final disease or condition resulting in death)
a. Congestive Heart Failure
Due to (or as a consequence of):
b. Inferior Myocardial Infarction
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
COPD | | | | | | | | | | 23b. Did tobacco use contribute to the cause of death?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | |
| | | | | | | | | | | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| | | | | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | 26. Place of Death (Check only one)
Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | | |
| | | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | 29b. Signature and title of certifier
 | | | 29c. License number
P09129 | | 29d. Date signed (Month, Day, Year)
May 28 1996 | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Michael Bong 301 St. Paul Place Balto MD 21202 | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
MAY 30 1996 | | | | | | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 24a show any injury or other traumatic event, the Medical Examiner must be notified at once.

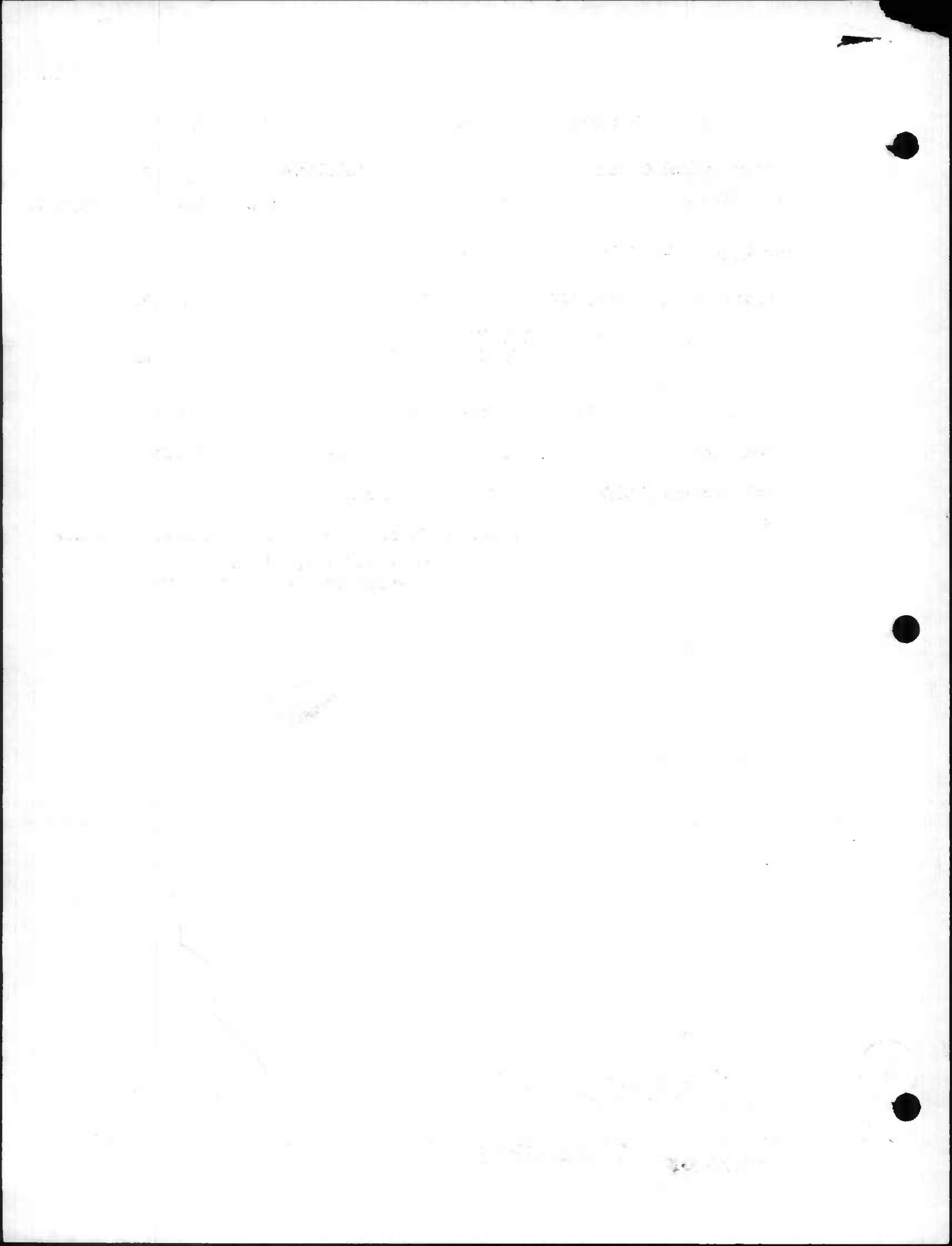
Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 72 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible 5928
State of Maryland / Department of Health and Mental Hygiene
Certificate of Death

Reg. No.

| | | | | | | | | | | |
|--|--|------------------------------------|--|---|--|---|---|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
CHARLES LEE McCORMACK | | | | | 2. Date of Death
Month Day Year
MAY 26 1996 | | 3. Time of Death
8:00 A.M. | | |
| | 4a. Facility Name (If not institution, give street and number)
1614 CHESAPEAKE DRIVE | | | | | 4b. City, Town, or Location of Death
EDGEWATER | | 4c. County of Death
ANNE ARUNDEL | | |
| Funeral
Director | 5. Social Security Number
452-36-1206 | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday)
68 Yrs. | | 8. Date of Birth (Month, Day, Year)
MARCH 29 1928 | | 9. Birthplace (State or Foreign Country)
ARKANSAS | |
| | Usual Residence of Decedent | | | | | | | | | |
| 10a. State
MARYLAND | | 10b. County
ANNE ARUNDEL | | 10c. City, Town or Location
EDGEWATER | | | | 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 10e. Street and Number
1614 CHESAPEAKE DRIVE | | | | | 10f. Zip Code
21037 | | 10g. Citizen of What Country?
USA | | | |
| 11. Marital Status
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | | 12. Was Decedent Ever in U.S. Armed Forces?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc.
Specify: WHITE | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 Collega (1-4or 5+) 2 | | | | | 18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
ELECTRICIAN | | | 16b. Kind of Business/Industry
COMMERCIAL CONSTRUCTION | | |
| 17. Father's Name (First, Middle, Last)
CHARLIE F. McCORMACK | | | | | 18. Mother's Name (First, Middle, Maiden Surname)
ELLORA JANE BROWN | | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
ROSE McCORMACK - SPOUSE | | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1614 CHESAPEAKE DRIVE, EDGEWATER, MD 21037 | | | | | |
| 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
MARYLAND VETERANS CEM. | | | 20c. Location - City or Town, State
5-31-96 CROWNSVILLE, MD | | | | |
| 21. Signature of Funeral Service Licensee

HILARY J. STALLINGS, JR. | | | | | 22. Name and Address of Facility
STALLINGS FUNERAL HOME, P.A.
3111 MOUNTAIN ROAD, PASADENA, MD 21122 | | | | | |
| 23a. Part I. Enter the disease, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

<div style="display: flex; justify-content: space-between;"> <div style="width: 80%;"> <p>Immediate Cause (Final disease or condition resulting in death)</p> <p style="text-align: center;">a. Lung Cancer</p> <p style="text-align: center;">Due to (or as a consequence of):</p> <p>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last</p> <p style="text-align: center;">b. Due to (or as a consequence of):</p> <p style="text-align: center;">c. Due to (or as a consequence of):</p> <p style="text-align: center;">d. Due to (or as a consequence of):</p> </div> <div style="width: 15%; text-align: center;"> <p>Approximate Interval Between Onset and Death</p> <p style="font-size: 1.5em;">18 months</p> </div> </div> | | | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | | | |
| 23b. Did tobacco use contribute to the cause of death?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | | | | | | |
| 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No | | | | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | |
| 29b. Signature and title of certifier

Wayne P. Biebaum | | | 29c. License number
038563 | | | 29d. Date signed (Month, Day, Year)
May 29, 1996 | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Wayne P. Biebaum 134 Owensville Rd, West River, MD | | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
MAY 3 01996 | | | 32. Registrar's Signature

Julia Davidson-Randall | | | | | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

X

x

— other
— upd.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 15929

Certificate of Death

Reg. No.

| | | | | | | | | |
|--|---|---|--|--|---|--|--|---|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
ALBERT VINCENT MURRAY | | | | 2. Date of Death
Month Day Year
MAY 25, 1996 | | 3. Time of Death
8:30 am | |
| | 4a. Facility Name (If not institution, give street and number)
GREATER BALTIMORE MEDICAL CENTER | | | | 4b. City, Town, or Location of Death
TOWSON | | 4c. County of Death
BALTIMORE | |
| Funeral
Director | 5. Social Security Number
232-05-1149 | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)
76 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth (Month, Day, Year)
Dec. 1, 1919 | 9. Birthplace (State or Foreign Country)
W. Va. |
| | Usual Residence of Decedent | | | | | | | |
| 10a. State
Md. | | 10b. County
Baltimore | | 10c. City, Town or Location
Towson | | 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 10e. Street and Number
127 Swarthmore Dr. | | | | 10f. Zip Code
21204 | | 10g. Citizen of What Country?
U.S.A. | | |
| 11. Marital Status
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
If Yes, Give Year or Dates: WW-II | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: White | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (1-4or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Salesman | | 16b. Kind of Business/Industry
Men's Clothing | | |
| 17. Father's Name (First, Middle, Last)
Jerome Vincent Murray | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Cytha Monteith | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
Mrs. Helen D. Murray | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
127 Swarthmore Dr. Towson, Md. 21204 | | | | |
| 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Dulaney Valley Mem. Gdns. | | Date
5/28/96 | | 20c. Location - City or Town, State
Timonium, Md. | | |
| 21. Signature of Funeral Service Licensee
 | | | | 22. Name and Address of Facility
Ruck Towson Funeral Home, Inc.
1050 York Rd. Towson, Md. 21204 | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
e. Aspiration Pneumonitis
Due to (or as a consequence of):
b. Generalized Seizure
Due to (or as a consequence of):
c. Glioblastoma Multiforme
Due to (or as a consequence of):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | | Approximate Interval Between Onset and Death
4 days
4 days
3 months |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Hypertension
Prior Colon carcinoma | | | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | |
| 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation
<input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier
William D. McConnell MD | | 29c. License number
042129 | | 29d. Date signed (Month, Day, Year)
5-25-96 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
William D. McConnell 500 W. University Baltimore | | | | | | | | |
| 31. Date filed (Month, Day, Year)
MAY 30 1996 | | | | 32. Registrar's Signature
 | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or item 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

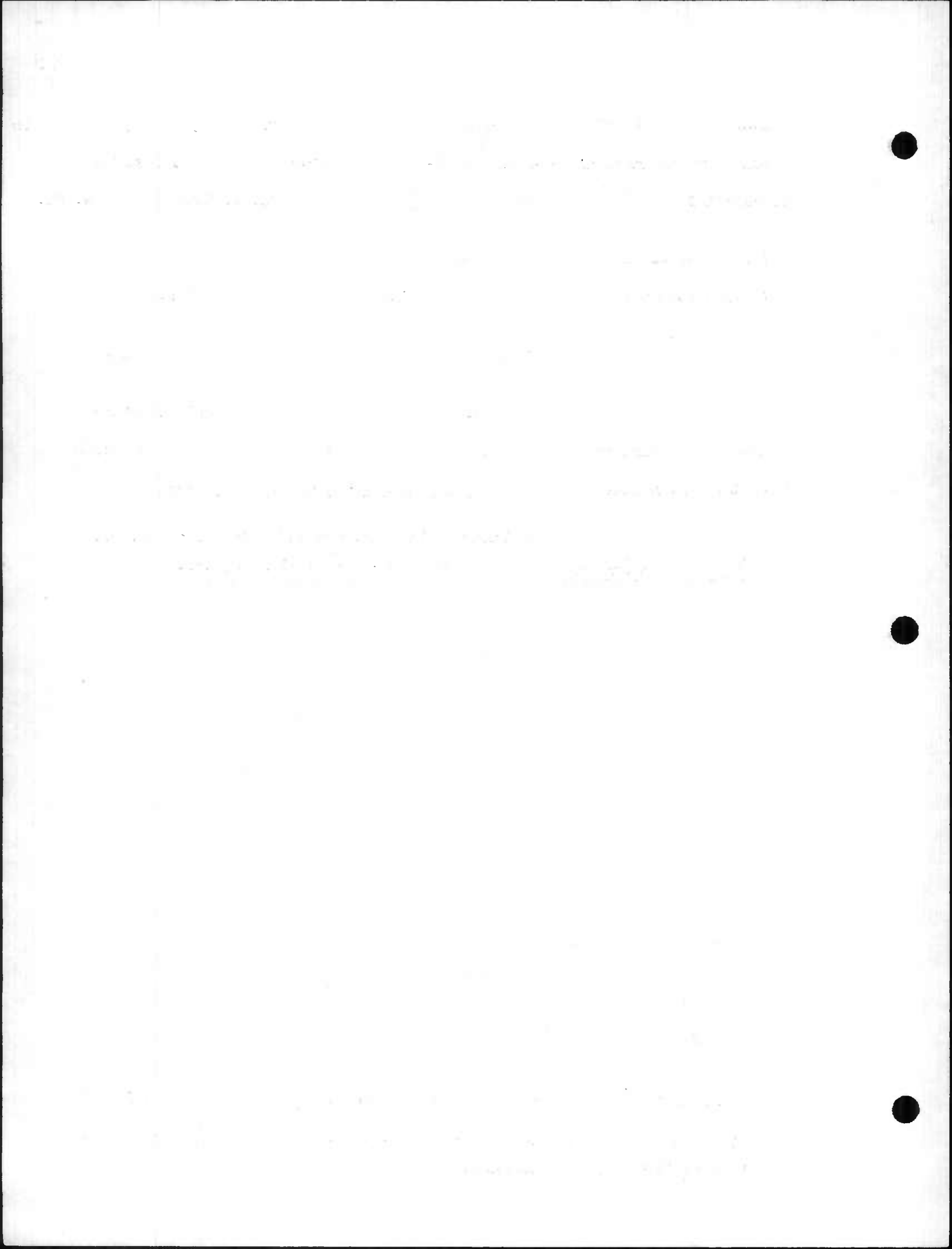
Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
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To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 15930

Certificate of Death

Reg. No.

| | | | | | | | | | |
|--|---|---|---|--|--|--|--|---|---|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
MITCHELL LOUIS MCGRAW | | | | 2. Date of Death
Month Day Year
MAY 24, 1996 | | 3. Time of Death
06:45 am | | |
| | 4a. Facility Name (If not institution, give street and number)
THE JOHNS HOPKINS HOSPITAL | | | | 4b. City, Town, or Location of Death
BALTIMORE CITY | | 4c. County of Death
n/a | | |
| Funeral
Director | 5. Social Security Number
215-84-7464 | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (in yrs. last birthday)
34 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth
Month, Day, Year
OCT 1, 1961 | | 9. Birthplace (State or Foreign Country)
BALTIMORE, MD | |
| | Usual Residence of Decedent | | | | | | | | |
| To Be Completed by Funeral Director | 10a. State
MD | | 10b. County
n/a | | 10c. City, Town or Location
BALTIMORE | | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | |
| | 10e. Street and Number
1903 BARCLAY STREET | | | | 10f. Zip Code
21218 | | 10g. Citizen of What Country?
UNITED STATES | | |
| | 11. Marital Status
<input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: BLACK | | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 8 th Collega (1-4 or 5+) - | | | 18e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
LABORER | | 16b. Kind of Business/Industry
unemployed | | | |
| | 17. Father's Name (First, Middle, Last)
RANDOLPH CARTER | | | | 18. Mother's Name (First, Middle, Maiden Surname)
ERNESTINE MC GRAW | | | | |
| | 19a. Informant's Name/Relationship (Type, Print)
ERNESTINE MC GRAW | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1903 BARCLAY STREET, BALTIMORE, MD | | | | |
| | 20e. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
VOSHELL MEMORIAL GARDENS 5-31 | | Date | | 20c. Location - City or Town, State
DUNDALK, MD | | |
| | 21. Signature of Funeral Service Licensee
Bernard D. Johnson | | | | 22. Name and Address of Facility
WM. C. MARCH FH.-1101 E. NORTH AVENUE | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
Immediate Cause (Final disease or condition resulting in death)
a. Progressive multifocal leukoencephalopathy
Due to (or as a consequence of):
b. Acquired Immunodeficiency Syndrome
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.
Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | | Approximate Interval Between Onset and Death
3 months
2 years |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | |
| | | | | | | 24a. Was an autopsy performed?
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | |
| | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | |
| 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 28. Place of Death (Check only one)
Hospital: <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation
2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined
3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | |
| | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | |
| 29b. Signature and title of certifier
Sherita A. Hill, MD Internal Medicine Housestaff | | | | 29c. License number
M6279 | | 29d. Date signed (Month, Day, Year)
May 24, 1996 | | | |
| 30. Name and address of person who completed cause of death (item 23a) (Type, Print)
Dr. Sherita A. Hill Tower 110 Doctor's Lounge Johns Hopkins Hospital Baltimore, MD 21287 | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
MAY 30 1996 | | 32. Registrar's Signature
John H. Sullivan-Randall | | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permt. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 72 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

96 15931

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
Amanda Lee Noppenberger | | | | 2. DATE OF DEATH
11/24 DAY 26, 1996 YEAR 11 P M | | 3. TIME OF DEATH | |
| 4. SOCIAL SECURITY NUMBER
214-08-7203 | | 5. SEX
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
14 YRS. | | 7. DATE OF BIRTH (Month, Day, Year)
March 25 1982 | |
| 8. BIRTHPLACE (State or Foreign Country)
Maryland | | 9a. FACILITY NAME (If not institution, give street and number)
13 Glen Falls Path | | 9b. CITY, TOWN OR LOCATION OF DEATH
Sparks | | 9c. COUNTY OF DEATH
Baltimore | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE
MD. | | 10b. COUNTY
Baltimore | | 10c. CITY, TOWN OR LOCATION
Sparks | | 10d. INSIDE CITY LIMITS?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 10e. STREET AND NUMBER
13 Glen Falls Path | | | | 10f. ZIP CODE
21152 | | 10g. CITIZEN OF WHAT COUNTRY?
USA | |
| 11. MARITAL STATUS
1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify: White | |
| 15. DECEDENT'S EDUCATION
(Specify only highest grade completed)
Elementary/Secondary (0-12)
8 | | 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.)
Student | | 16b. KIND OF BUSINESS/INDUSTRY
N/A | | | |
| 17. FATHER'S NAME (First, Middle, Last)
Wayne Noppenberger | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Kelly Lee Harris | | | |
| 19a. INFORMANT'S NAME (Type/Print)
Kelly Noppenberger | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
13 Glen Falls Path Sparks, Md. 21152 | | | |
| 20a. METHOD OF DISPOSITION
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
Dulaney Valley Cem. | | 20c. DATE
5-30-96 | | 20d. LOCATION — City or Town, State
Timonium, Md. | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
K. J. [Signature] | | | | 22. NAME AND ADDRESS OF FACILITY
Ruck Towson Funeral Home, Inc.
1050 York Rd. Towson, Md. 21204 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → Asphyxia from Hanging | | | | | | | |
| Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA
OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH
1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation
2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined
3 <input checked="" type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year)
5-26-96 | | 28b. TIME OF INJURY
11 P M | | 28c. INJURY AT WORK?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED
Hung Self | | 28e. PLACE OF INJURY — At home, farm, street, lecture, office building, etc. (Specify)
At Home | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
13 Glen Falls Path Sparks, Md. | | | |
| 29a. CERTIFIER (Check only one)
1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
Charles F. O'Donnell | | | | 29c. LICENSE NUMBER
D-09383 | | 29d. DATE SIGNED (Month, Day, Year)
May 27, 1996 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
Charles F. O'Donnell - 111 Hamlet Hill Rd Baltimore Md | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
MAY 30 1996 | | | | 32. REGISTRAR'S SIGNATURE
John Davidson-Randall | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

96 15932

Certificate of Death

Reg. No.

| | | | | | | | | | |
|--|---|---|--|--|--------------------------------|--|---|---|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
DR. MICHAEL DAVID O'MANSKY | | | 2. Date of Death
Month May Day 25 Year 1996 | | 3. Time of Death
12:01 pm | | | |
| | 4a. Facility Name (If not institution, give street and number)
2 SAXONY COURT | | | 4b. City, Town, or Location of Death
BALTIMORE | | 4c. County of Death
BALTIMORE | | | |
| Funeral
Director | 5. Social Security Number
220-52-6299 | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)
30 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth (Month, Day, Year)
JUNE 29, 1965 | 9. Birthplace (State or Foreign Country)
MARYLAND | |
| | Usual Residence of Decedent | | | | | | | | |
| 10a. State
MARYLAND | | 10b. County
BALTIMORE | | 10c. City, Town or Location
BALTIMORE | | 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | |
| 10e. Street and Number
12 ESTATES COURT, APT. 5410 | | | | 10f. Zip Code
21208 | | 10g. Citizen of What Country?
USA | | | |
| 11. Marital Status
<input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: WHITE | | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 5+ College (1-4 or 5+) 5+ | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
PHYSICIAN | | 16b. Kind of Business/Industry
MEDICINE | | | |
| 17. Father's Name (First, Middle, Last)
DR. SAMUEL O'MANSKY | | | | 18. Mother's Name (First, Middle, Maiden Surname)
ELAINE FUCHS | | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
DR. SAMUEL O'MANSKY (FATHER) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
2 SAXONY COURT BALTIMORE, MD 21208 | | | | | |
| 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
OHEB SHALOM MEMORIAL PARK - 5-28-1996- REISTERSTOWN, MD | | Date | | 20c. Location - City or Town, State | | | |
| 21. Signature of Funeral Service Licensee
<i>Scott M. Cutler</i> | | | | 22. Name and Address of Facility
SOL LEVINSON & BROS., INC.
8900 REISTERSTOWN ROAD PIKESVILLE, MD 21208 | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
<i>Carbon Monoxide Poison</i>
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of): | | | | | | | | Approximate interval Between Onset and Death | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | |
| | | | | | | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | |
| | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | |
| 25. Was case referred to medical examiner?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. Manner of Death
<input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year)
MAY 25, 1996 | | 28b. Time of Injury
3:30 PM | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred
INHALED EXHAUST FUMES FROM AUTO | |
| | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
GARAGE | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State)
2 SAXONY CT. BALTO. CO., MD. | | | |
| 29a. Certifier (Check only one)
<input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier
<i>Charles F. O'Donnell</i> | | | | | | 29c. License number
D-09383 | |
| | | 29d. Date signed (Month, Day, Year)
26 May 96 | | | | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Charles F. O'Donnell 111 Hamlet Hill Rd Baltimore Md | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
MAY 30 1996 | | 32. Registrar's Signature
<i>John...</i> | | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 15933

Certificate of Death

Reg. No.

| | | | | | | | | | | | | | | | | | | | | | | | |
|---|--|----------------------------------|---|---|---|---|--|--|---|--|---|--|----------------------------------|---|--|--|-----------------|---|----------------------------------|----------------|----------|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
<i>Alice Frances O'Connor</i> | | | | | | 2. Date of Death
Month <i>May</i> Day <i>24</i> Year <i>1996</i> | | 3. Time of Death
<i>19:10pm</i> | | | | | | | | | | | | | | |
| | 4a. Facility Name (If not institution, give street and number)
<i>St. Agnes Hospital</i> | | | | | | 4b. City, Town, or Location of Death
<i>Baltimore</i> | | 4c. County of Death
<i>N/A</i> | | | | | | | | | | | | | | |
| Funeral
Director | 5. Social Security Number
<i>219-01-8460</i> | | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday)
<i>76</i> Yrs. | | 8. Date of Birth (Month, Day, Year)
<i>May 9, 1920</i> | | 9. Birthplace (State or Foreign Country)
<i>MD</i> | | | | | | | | | | | | | | |
| | 10a. State
<i>MD</i> | | 10b. County
<i>Baltimore</i> | | 10c. City, Town or Location
<i>Catonsville</i> | | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | | | | | | | | | | |
| Usual Residence of Decedent | | | | | | | | | | | | | | | | | | | | | | | |
| 10e. Street and Number
<i>1204 Tugwell Drive</i> | | | | 10f. Zip Code
<i>21228</i> | | | | 10g. Citizen of What Country?
<i>USA</i> | | | | | | | | | | | | | | | |
| 11. Marital Status
<input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc.
Specify: <i>white</i> | | | | | | | | | | | | | | |
| 15. Decedent's Education (Specify only highest grade completed)
<i>Elementary/Secondary (0-12)</i>
<i>12</i> | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
<i>Secretary</i> | | | | 16b. Kind of Business/Industry
<i>Seminary</i> | | | | | | | | | | | | | | | |
| 17. Father's Name (First, Middle, Last)
<i>Matthew David O'Connor</i> | | | | | | 18. Mother's Name (First, Middle, Maiden Surname)
<i>Theresa Walter</i> | | | | | | | | | | | | | | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
<i>Matt Burroughs/nephew</i> | | | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
<i>101 Parkview Dr. Painted Post, N.Y. 14870</i> | | | | | | | | | | | | | | | | | |
| 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
<i>New Cathedral Cem</i> | | | | 20c. Location - City or Town, State
<i>5/28/96 Balto, Md.</i> | | | | | | | | | | | | | | | |
| 21. Signature of Funeral Service Licensee
<i>Robert S. Ashton</i> | | | | | | 22. Name and Address of Facility
<i>Sterling Ashton Funeral Home</i>
<i>736 Edmondson Avenue, Balto, Md. 21228</i> | | | | | | | | | | | | | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | | | | | | | | | | | | | | | | | |
| <table border="0"> <tr> <td rowspan="4"> Immediate Cause (Final disease or condition resulting in death)

 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last </td> <td>a. <i>Advanced Metastatic Carcinoma</i></td> <td>Due to (or as a consequence of):</td> <td><i>3 months</i></td> </tr> <tr> <td>b. <i>Small Cell Carcinoma of the lung</i></td> <td>Due to (or as a consequence of):</td> <td><i>6 months</i></td> </tr> <tr> <td>c. <i>Metastatic disease to the Brain</i></td> <td>Due to (or as a consequence of):</td> <td><i>3 weeks</i></td> </tr> <tr> <td>d. _____</td> <td></td> <td></td> </tr> </table> | | | | | | | | | | | Immediate Cause (Final disease or condition resulting in death)

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | a. <i>Advanced Metastatic Carcinoma</i> | Due to (or as a consequence of): | <i>3 months</i> | b. <i>Small Cell Carcinoma of the lung</i> | Due to (or as a consequence of): | <i>6 months</i> | c. <i>Metastatic disease to the Brain</i> | Due to (or as a consequence of): | <i>3 weeks</i> | d. _____ | | |
| Immediate Cause (Final disease or condition resulting in death)

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | a. <i>Advanced Metastatic Carcinoma</i> | Due to (or as a consequence of): | <i>3 months</i> | | | | | | | | | | | | | | | | | | | | |
| | b. <i>Small Cell Carcinoma of the lung</i> | Due to (or as a consequence of): | <i>6 months</i> | | | | | | | | | | | | | | | | | | | | |
| | c. <i>Metastatic disease to the Brain</i> | Due to (or as a consequence of): | <i>3 weeks</i> | | | | | | | | | | | | | | | | | | | | |
| | d. _____ | | | | | | | | | | | | | | | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | | | | | | | | | | | | | | | | |
| <table border="0"> <tr> <td><i>Dehydration</i></td> <td>23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown</td> </tr> <tr> <td></td> <td>24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</td> </tr> <tr> <td></td> <td>24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</td> </tr> </table> | | | | | | | | | | | <i>Dehydration</i> | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown | | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | |
| <i>Dehydration</i> | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | | | | | | | | | | | | | | | | | | |
| | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | | | | | | | | | | | | | | | |
| | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | | | | | | | | | | | | | | | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | 26. Place of Death (Check only one)
Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | | | | | | | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
<i>M</i> | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input type="checkbox"/> No | | 28d. Describe how injury occurred | | | | | | | | | | | | | | |
| 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | | | | | | | | | | |
| 29e. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | | | | | | | | | | | | | | |
| 29b. Signature and title of certifier
<i>[Signature]</i> | | | | | | 29c. License number
<i>P09140</i> | | 29d. Date signed (Month, Day, Year)
<i>MAY 24, 1996</i> | | | | | | | | | | | | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
<i>MUNIR RAHAL, ST. Agnes Hospital, 900 Caton Ave, Baltimore, MD 21229</i> | | | | | | | | | | | | | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
<i>MAY 3 01996</i> | | | | | | | | | | | | | | | | | | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

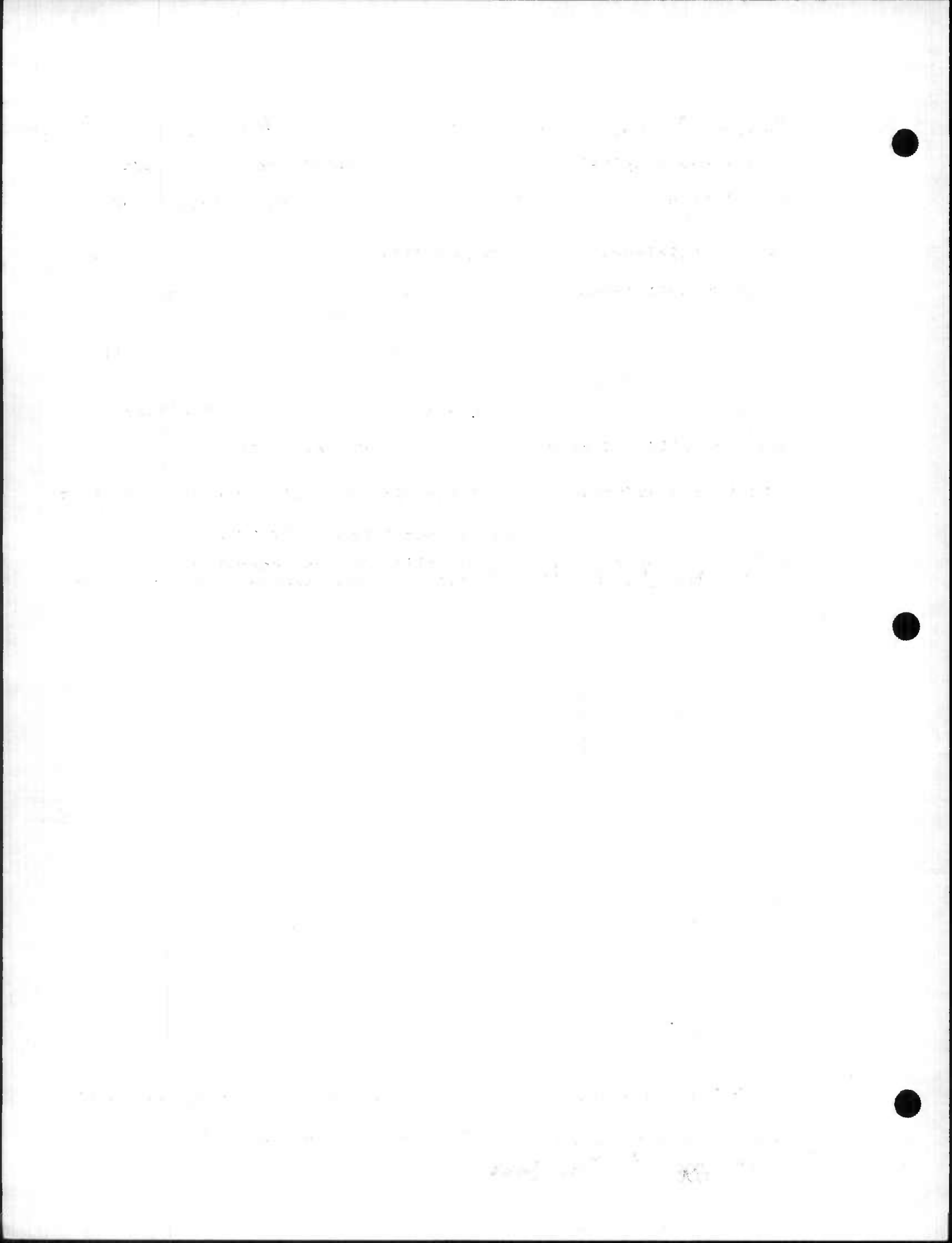
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner


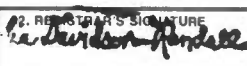
State Registrar



96 15934

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | |
|--|--|--|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
Edwin Richard Peightal, Sr. | | 2. DATE OF DEATH
MONTH May DAY 27 YEAR 1996 | | 3. TIME OF DEATH
9:20 AM | |
| 4. SOCIAL SECURITY NUMBER
175-12-2329 | | 5. SEX
XX M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
80 YRS. | |
| 7. DATE OF BIRTH
(Month, Day, Year)
Feb. 11, 1916 | | 8. BIRTHPLACE (State or Foreign Country)
Pennsylvania | | | |
| 9a. FACILITY NAME (If not institution, give street and number)
Ivy Hall Nursing Home | | 9b. CITY, TOWN OR LOCATION OF DEATH
Middle River | | 9c. COUNTY OF DEATH
Baltimore | |
| RESIDENCE OF DECEDENT | | | | | |
| 10a. STATE
Maryland | | 10b. COUNTY
Baltimore | | 10c. CITY, TOWN OR LOCATION
Essex | |
| 10d. INSIDE CITY LIMITS?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | | |
| 10e. STREET AND NUMBER
1113 Apt. A Old Eastern Avenue | | 10f. ZIP CODE
21221 | | 10g. CITIZEN OF WHAT COUNTRY?
United States | |
| 11. MARITAL STATUS
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO
IF YES, GIVE WAR OR DATES WWII | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yaa or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | |
| 14. RACE — American Indian, Black, White, etc.
Specify: White | | | | | |
| 15. DECEDENT'S EDUCATION
(Specify only highest grade completed) | | 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.) | | 16b. KIND OF BUSINESS/INDUSTRY | |
| Elementary/Secondary (0-12)
8 Years | | College (1-4 or 5+) | | Bus Driver | |
| Transportation | | | | | |
| 17. FATHER'S NAME (First, Middle, Last)
Richard Peightal | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Daisy Applebaugh | | | |
| 19a. INFORMANT'S NAME (Type/Print)
Mrs. Irene Carnell Peightal | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1113 Old Eastern Ave. Apt. A Baltimore, MD 21221 | | | |
| 20a. METHOD OF DISPOSITION
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
Garrison Forest V.A. Cem. 5/31/96 | | 20c. LOCATION — City or Town, State
Owings Mills, MD | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
 | | 22. NAME AND ADDRESS OF FACILITY
Duda-Ruck Funeral Home of Dundalk, Inc.
7922 Wise Ave. Dundalk, Maryland 21222 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | | a. Carcinoma of the Lung
DUE TO (OR AS A CONSEQUENCE OF): | | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | b. DUE TO (OR AS A CONSEQUENCE OF): | | | |
| | | c. DUE TO (OR AS A CONSEQUENCE OF): | | | |
| | | d. DUE TO (OR AS A CONSEQUENCE OF): | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Insulin Dependent Diabetes Mellitus, Chronic
Bronchitis, Old Cerebrovascular Accident
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
<input type="checkbox"/> YES <input type="checkbox"/> NO | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA
OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | |
| 27. MANNER OF DEATH
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation
<input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined
<input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M <input type="checkbox"/> YES <input type="checkbox"/> NO | |
| 28c. INJURY AT WORK?
<input type="checkbox"/> YES <input type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. CERTIFIER (Check only one)
<input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
Ba Yin Oung, M.D. | | 29c. LICENSE NUMBER
D17728 | | 29d. DATE SIGNED (Month, Day, Year)
May 28, 1996 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
Ba Yin Oung, M.D. 8022 Belair Rd. Balto., MD 21236 | | | | | |
| 31. DATE FILED (Month, Day, Year)
MAY 30 1996 | | 32. REGISTRAR'S SIGNATURE
 | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit certificate.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

241

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

Film G735 item 20a per FH 5-30-96 rja

State of Maryland / Department of Health and Mental Hygiene

96 15935

Item: 26, per Dr. G-736 6/17/96 d.d.

Certificate of Death

Reg. No.

| | | | | | |
|---|---|--|--|---|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
GAIL S. POSTER | | 2. Date of Death
Month Day Year
MAY 28, 1996 | | 3. Time of Death
12:35am |
| | 4a. Facility Name (If not institution, give street and number)
MERCY HOSPITAL | | 4b. City, Town, or Location of Death
BALTIMORE | | 4c. County of Death
N/A |
| Funeral
Director | 5. Social Security Number
269-14-0776 | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)
78 Yrs. | If Under 1 Year
Months Days
0 0 | If Under 24 Hrs.
Hours Min.
0 0 |
| | 8. Date of Birth (Month, Day, Year)
MAR. 6, 1918 | | 9. Birthplace (State or Foreign Country)
MARYLAND | | |
| Usual Residence of Decedent | | | | | |
| 10a. State
MARYLAND | | 10b. County
N/A | | 10c. City, Town or Location
BALTIMORE | |
| 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | 10e. Street and Number
1101 N. CALVERT ST., APT. 1807 | |
| 10f. Zip Code
21202 | | | | 10g. Citizen of What Country?
USA | |
| 11. Marital Status
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | |
| 14. Race - American Indian, Black, White, etc.
Specify:
WHITE | | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (1-4 or 5+) | | | |
| 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
REALTOR | | 16b. Kind of Business/Industry
REAL ESTATE | | | |
| 17. Father's Name (First, Middle, Last)
HERBERT SNYDER | | | 18. Mother's Name (First, Middle, Maiden Surname)
MAUDE WOLFE | | |
| 19a. Informant's Name/Relationship (Type, Print)
DR. BENJAMIN L. POSTER (HUSBAND) | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1101 N. CALVERT ST., APT. 1807 BALTIMORE, MD 21202 | | |
| 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
HILLTOP SERVICE CORP. | | 20c. Date
5-29-1996 | |
| 20d. Location - City or Town, State
TOWSON, MD | | 21. Signature of Funeral Service Licensee
<i>Scott M. Gutt</i> | | | |
| 22. Name and Address of Facility
SOL LEVINSON & BROS., INC. | | 22. Address of Facility
8900 REISTERSTOWN ROAD PIKESVILLE, MD 21208 | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. Acute myocardial Infarction 1 hr.
Due to (or as a consequence of):
b. Atherosclerotic coronary artery disease yrs.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d. | | | | | |
| 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | |
| 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Hypertension
Hypochloremic dehydration | | | | | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input checked="" type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | |
| 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | | 28e. Location (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | |
| 29b. Signature and title of certifier
<i>James E. Gutz</i> | | 29c. License number
001442 | | 29d. Date signed (Month, Day, Year)
5/28/96 | |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)
LOUIS E. GUTZ, M.D. 301 ST. P. - 1 ST. S. - 815 B. 1st Md 21202 | | | | | |
| 31. Date filed (Month, Day, Year)
MAY 30 1996 | | 32. Registrar's Signature
<i>J. Davidson-Randall</i> | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Figure 6

Figure 6 displays two bar charts comparing the number of cases across different categories for two groups: "All Cases" and "Cases with Significant Risk Factor". The x-axis lists categories: "No Significant Risk Factor", "Significant Risk Factor", "Unknown", "Other", "Total", and "Subtotal". The y-axis represents the count, ranging from 0 to 100.

The first chart, titled "All Cases", shows the following approximate values:

| Category | All Cases |
|----------------------------|-----------|
| No Significant Risk Factor | 78 |
| Significant Risk Factor | 22 |
| Unknown | 10 |
| Other | 5 |
| Total | 115 |
| Subtotal | 115 |

The second chart, titled "Cases with Significant Risk Factor", shows the following approximate values:

| Category | Cases with Significant Risk Factor |
|----------------------------|------------------------------------|
| No Significant Risk Factor | 15 |
| Significant Risk Factor | 10 |
| Unknown | 5 |
| Other | 2 |
| Total | 32 |
| Subtotal | 32 |

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

96 15936

Reg. No.

Physician
/Medical
ExaminerFuneral
Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

| | | | | | |
|--|--|---|--|---|--|
| 1. Decedent's Name (First, Middle, Last)
ANTHONY PERKINS Jr. | | 2. Date of Death
Month Day Year
MAY 23, 1996 | | 3. Time of Death
7:35 a | |
| 4a. Facility Name (If not institution, give street and number)
THE JOHNS HOPKINS HOSPITAL | | 4b. City, Town, or Location of Death
BALTIMORE CITY | | 4c. County of Death
n/a | |
| 5. Social Security Number | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)
1 Yrs. | If Under 1 Year
Months Days
2 | If Under 24 Hrs.
Hours Min.
02-27-95 | 8. Date of Birth (Month, Day, Year) |
| 9. Birthplace (State or Foreign Country)
Maryland | | | | | |
| Usual Residence of Decedent | | | | | |
| 10a. State
Maryland | 10b. County
N/A | 10c. City, Town or Location
Baltimore | | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | |
| 10e. Street and Number
3 Eddystone Place | | 10f. Zip Code
21221 | | 10g. Citizen of What Country?
United States | |
| 11. Marital Status
<input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No)
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | |
| 14. Race - American Indian, Black, White, etc.
Specify: Black | | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) - College (1-4or 5+) - | | | |
| 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
BABY | | 16b. Kind of Business/Industry
Baby | | | |
| 17. Father's Name (First, Middle, Last)
Anthony Perkins, Sr. | | | 18. Mother's Name (First, Middle, Maiden Surname)
Averie Green | | |
| 19a. Informant's Name/Relationship (Type, Print)
Mr. & Mrs. Anthony Perkins, Sr. | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
3 Eddystone Place, Baltimore, MD 21221 | | | |
| 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Arbutus Memorial Park | | 20c. Location - City or Town, State
5-29-96 Arbutus, Maryland | |
| 21. Signature of Funeral Service Licensee
 | | 22. Name and Address of Facility
March Funeral Home
1101 E. North Avenue, Baltimore, MD 21202 | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

a. Cardiac arrhythmia
Due to (or as a consequence of):
b. Hypoxemia
Due to (or as a consequence of):
c. Cardiomyopathy
Due to (or as a consequence of):
d.

Approximate Interval Between Onset and Death
2 hrs.
6 hrs.
3 hrs. | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |
| | | | | | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| 25. Was case referred to medical examiner?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation
<input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined
<input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | |
| | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | |
| | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | |
| 29b. Signature and title of certifier

Allen R. Walker
Attending Physician
Pediatric E.D. | | 29c. License number
D31403 | | 29d. Date signed (Month, Day, Year)
May 23, 1996 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Allen R. Walker
CMSE-144
The Johns Hopkins Hospital, Baltimore, MD. | | | | | |
| 31. Date filed (Month, Day, Year)
MAY 30 1996 | | 32. Registrar's Signature
 | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

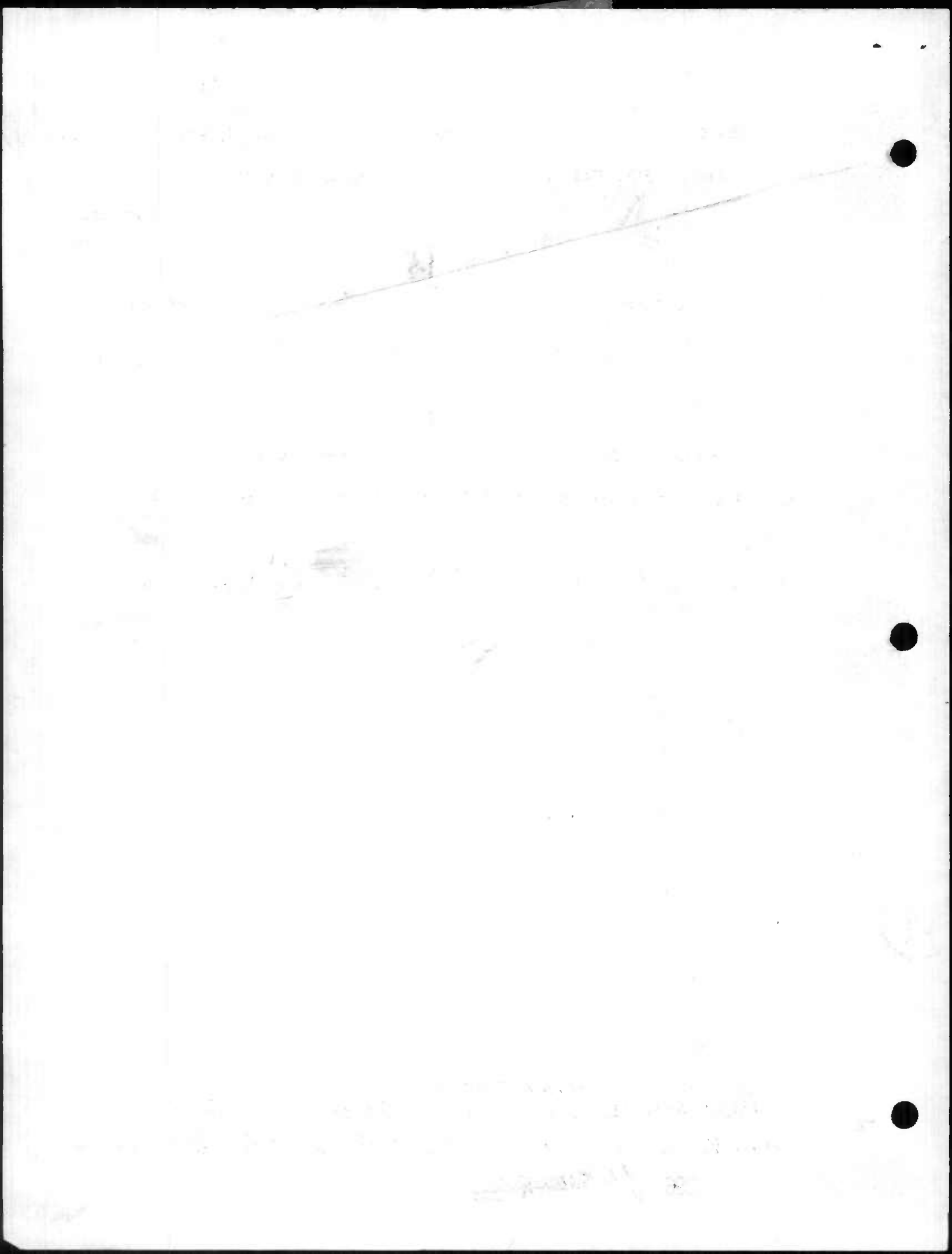
Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: This law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

2

State
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 15937

Certificate of Death

Reg. No.

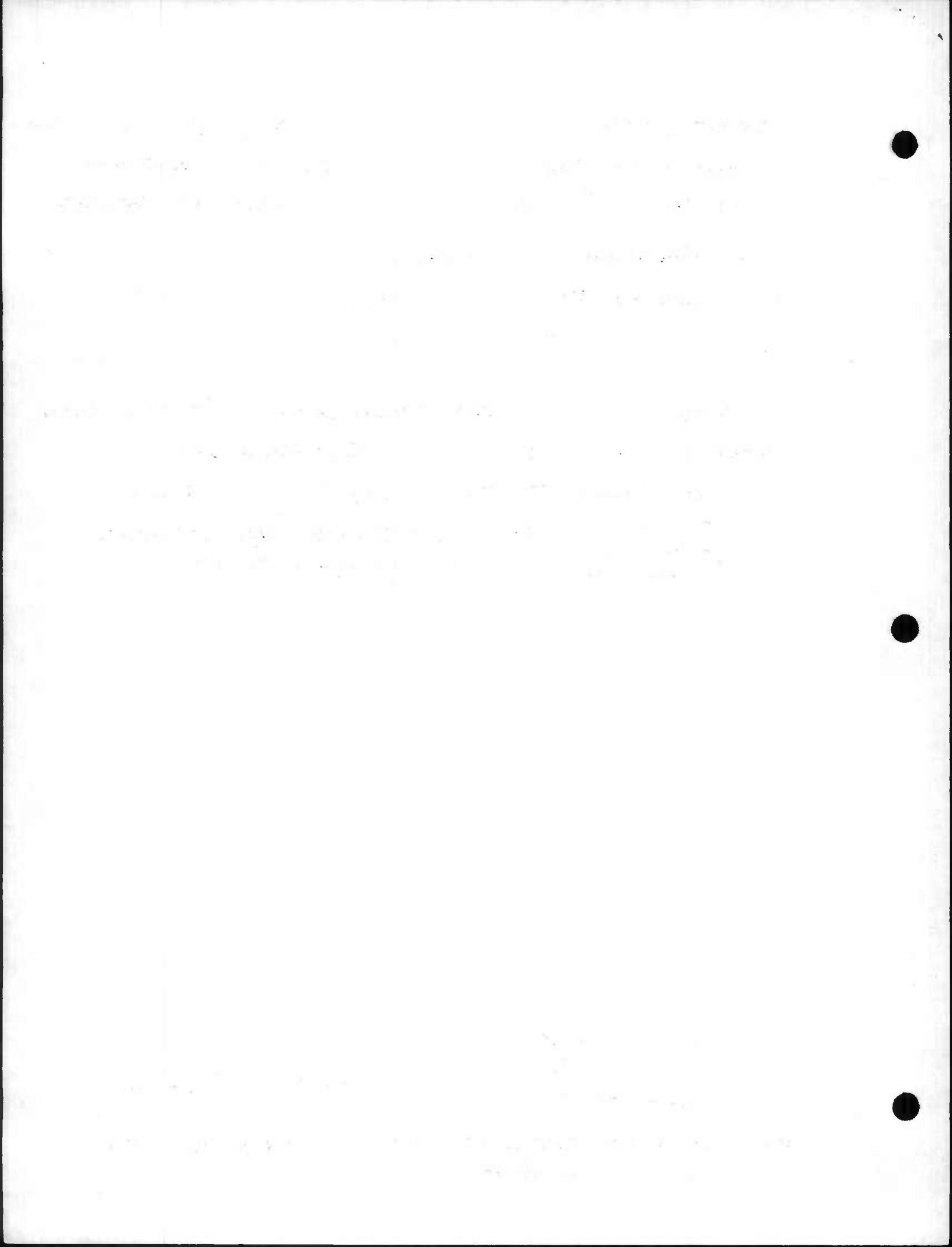
| | | | | | | | | | | |
|--|--|--|--|--|--|--|--|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
ALMA MARIE QUIJARRO | | | | 2. Date of Death
Month Day Year
MAY 25 1996 | | | | 3. Time of Death
6:15AM | |
| | 4a. Facility Name (If not institution, give street and number)
STELLA MARIS HOSPICE | | | | 4b. City, Town, or Location of Death
TOWSON | | | | 4c. County of Death
BALTIMORE | |
| Funeral
Director | 5. Social Security Number
213-34-1481 | | 6. Sex
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday)
82 yrs. | | If Under 1 Year
Months Days | | If Under 24 Hrs.
Hours Min. | |
| | 8. Date of Birth (Month, Day, Year)
AUG 15, 1913 | | 9. Birthplace (State or Foreign Country)
MARYLAND | | Usual Residence of Decedent | | | | | |
| To Be Completed by Funeral Director | 10a. State
MD. | | 10b. County
BALTIMORE | | 10c. City, Town or Location
TOWSON | | | | 10d. Inside City Limits
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | |
| | 10a. Street and Number
1310 COLBURY RD. | | | | 10f. Zip Code
21239 | | 10g. Citizen of What Country?
U.S.A. | | | |
| | 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: WHITE | | | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 8 YRS
College (1-4 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
TELE COMMUNICATIONS | | 16b. Kind of Business/Industry
GOOD SAMARITAN | | | | | |
| To Be Completed by Physician/Medical Examiner | 17. Father's Name (First, Middle, Last)
ELMER E. LINDEMORE | | | | 18. Mother's Name (First, Middle, Maiden Summa)
ELIZABETH CULVER | | | | | |
| | 19a. Informant's Name/Relationship (Type, Print)
DOLORES EHRHARDT | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1310 COLBURY RD. 21239 | | | | | |
| | 20a. Method of Disposition
1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
GREENMOUNT CREMATORY | | Data
5/27 | | 20c. Location - City or Town, State
BALTIMORE | | | |
| | 21. Signature of Funeral Service Licensee
 | | 22. Name and Address of Facility
EVANS CHAPEL OF MEMORIES
8800 HARFORD RD. 21234 | | | | | | | |
| Physician
/Medical
Examiner | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. Gangrene R foot
Due to (or as a consequence of):
b. Peripheral Vascular Disease
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | | Approximate Interval Between Onset and Death
2 months
years | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown | |
| | | | | | | | | | 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | |
| | | | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | |
| Medical Certification: To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) Hospice | | | | | | | |
| | 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation
2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined
3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how Injury occurred | |
| | 29a. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier
 | | 29c. License number
115504 | | 29d. Date signed (Month, Day, Year)
5-28-96 | | | |
| | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
DR. EDDIE NAKHODA 2300 DULANEY VALLEY RD., TOWSON, MD 21204 | | | | | | | | | |
| State
Registrar | 31. Date filed (Month, Day, Year)
MAY 30 1996 | | 32. Registrar's Signature
 | | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 15938

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedant's Name (First, Middle, Last)

RHEA

REID

2. Date of Death

Month Day Year
05/29/1996

3. Time of Death

10:30AM

4a. Facility Name (If not institution, give street and number)

3 SONYA COURT

4b. City, Town, or Location of Death

RANDALLSTOWN

4c. County of Death

BALTIMORE

Funeral
Director

5. Social Security Number

105-30-1373

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

56

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
06/17/1939

9. Birthplace (State or Foreign Country)

NEW YORK

Usual Residence of Decedent

10a. State

NEW YORK

10b. County

QUEENS

10c. City, Town or Location

LAURELTON

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

130-09 224th STREET

10f. Zip Code

11413

10g. Citizen of What Country?

US

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: BLK.

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4or 5+)

2

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

VICE PRESIDENT

16b. Kind of Business/Industry

BANKING

17. Father's Name (First, Middle, Last)

HILDRED

COLLINS

18. Mother's Name (First, Middle, Maiden Surname)

VIVIAN

BRANTLY

19a. Informant's Name/Relationship (Type, Print)

WAYNE REID (SON)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

5877 CROTON CIRCLE INDIANAPOLIS, IND. 46254

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☒ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

CALVERTON CEMETERY

Date

6/4/96

20c. Location - City or Town, State

LONG ISLAND, N.Y.

21. Signature of Funeral Service Licensee

CFSP #281

22. Name and Address of Facility

PHILLIPS FUNERAL HOME

1721-27 N. MONROE ST. BALTIMORE, MD. 21217

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. BREAST CANCER
Due to (or as a consequence of):

Approximate interval between Onset and Death

15 mos

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

035606

29d. Date signed (Month, Day, Year)

5/30/96

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SAMUEL ZILBER 21 CROSSROAD DR OUTHWICK MD 21117

31. Date filed (Month, Day, Year)

MAY 30 1996

32. Registrar's Signature

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

96 15939

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|--|---|--|--|---|
| 1. DECEDENT'S NAME (First, Middle, Last)
OLGA L. Renzi | | | | 2. DATE OF DEATH
MONTH MAY DAY 29 YEAR 1996 | | 3. TIME OF DEATH
12:45 AM | |
| 4. SOCIAL SECURITY NUMBER
224874359 | | 5. SEX
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
89 YRS. | | 7. DATE OF BIRTH (Month, Day, Year)
JAN. 26 1906 | |
| 8. BIRTHPLACE (State or Foreign Country)
MARYLAND | | | | 9a. FACILITY NAME (If not institution, give street and number)
AUGSBURG LUTHERAN HOME | | 9b. CITY, TOWN OR LOCATION OF DEATH
BALTIMORE | |
| 9c. COUNTY OF DEATH | | | | 10a. STATE
MARYLAND | | 10b. COUNTY | |
| 10c. CITY, TOWN OR LOCATION
BALTIMORE | | | | 10d. INSIDE CITY LIMITS?
<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | 10e. STREET AND NUMBER
6811 LAMPFIELD ROAD | |
| 10f. ZIP CODE
21207 | | | | 10g. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 11. MARITAL STATUS
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify:
WHITE | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (9-12) 12 YRS. College (1-4 or 5+) 6 YRS. | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
SOCIAL WORKER | | 16b. KIND OF BUSINESS/INDUSTRY
STATE OF MARYLAND | |
| 17. FATHER'S NAME (First, Middle, Last)
THEODORE PLAWIN | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
ELLA SCHMIOT | | | |
| 19a. INFORMANT'S NAME (Type/Print)
JOYCE RENZI BROWN | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
4 SYCAMORE ROAD HUMMELSTOWN, PENNSYLVANIA 17036 | | | |
| 20a. METHOD OF DISPOSITION
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
IMMANUEL LUTHERAN 8-31 | | 20c. LOCATION — City or Town, State
BALTIMORE, MARYLAND | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
<i>[Signature]</i> | | | | 22. NAME AND ADDRESS OF FACILITY
EVANS CHAPEL OF CHIMES
2325 YORK ROAD - Timonium | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Ruptured Abdominal Aortic Aneurysm
DUE TO (OR AS A CONSEQUENCE OF):
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. DUE TO (OR AS A CONSEQUENCE OF):
c. DUE TO (OR AS A CONSEQUENCE OF):
d. | | | | | | | Approximate Interval Between Onset and Death
3 weeks |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | 24a. WAS AN AUTOPSY PERFORMED?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | | | | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA
OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M | | 28c. INJURY AT WORK?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 28d. DESCRIBE NOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. CERTIFIER (Check only one)
<input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
<i>Deborah Irene Pierce</i> | | | | 29c. LICENSE NUMBER
D45931 | | 29d. DATE SIGNED (Month, Day, Year)
May twenty ninth, 1996 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
DR. DEBORAH IRENE PIERCE 7220 PARK HEIGHTS AVE | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
MAY 30 1996 | | | | 32. REGISTRAR'S SIGNATURE
<i>[Signature]</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 15940

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Norman Reginald Ross Jr.

2. Date of Death
Month Day Year

May 27, 1996

3. Time of Death

11:15p.m.

4a. Facility Name (If not institution, give street and number)

9619 Winards Road

4b. City, Town, or Location of Death

Randallstown

4c. County of Death

Baltimore

Funeral
Director

5. Social Security Number

212-80-1301

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

35 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth
(Month, Day, Year)

Nov 9, 1960

9. Birthplace (State or Foreign
Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Randallstown

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

9619 Winards Road

10f. Zip Code

21133

10g. Citizen of What Country?

USA

11. Marital Status

☒ Never Married ☐ Married
☐ Widowed ☐ Divorced12. Was Decedent Ever in U.S.
Armed Forces?☐ Yes ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)☐ Yes ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: Black

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4or 5+)

3 Years

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Retail Assoc.

16b. Kind of Business/Industry

Comme de Garebron

17. Father's Name (First, Middle, Last)

Norman E. Ross Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Ruth Fisher

19a. Informant's Name/Relationship (Type, Print)

Norman E. Ross Jr.

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

9619 Winards Rd. Baltimore, Maryland 21133

20a. Method of Disposition

☐ Burial ☒ Cremation ☐ Removal from State
☐ Donation ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Metro Crematory

Date

5/29/96

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Nutter Funeral Homes Inc.
2501 Gwynns Falls PKY Balt. Md. 2121623a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)a. Respiratory Failure
Due to (or as a consequence of):Approximate
Interval Between
Onset and Death

minutes

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or Injury
that initiated events
resulting in death) Lastb. Kaposi's Sarcoma
Due to (or as a consequence of):

12 months

c. Acquired Immunodeficiency
Due to (or as a consequence of):

> 5 yrs

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

none

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown24a. Was an autopsy
performed?☐ Yes ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?☐ Yes ☒ No25. Was case referred to medical
examiner?
☐ Yes ☒ No

Hospital:

☐ Inpatient ☐ ER/Outpatient ☐ DOA

26. Place of Death (Check only one)

Other: ☐ Nursing Home ☒ Residence ☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending
investigation
☐ Accident ☐ Could not be
determined
☐ Suicide ☐ Homicide28a. Date of Injury
(Month, Day Year)28b. Time of
Injury28c. Injury at
Work?☐ Yes ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

29c. License number

D38637

29d. Date signed (Month, Day, Year)

5/29/96

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

UMM Med Ctr, 29 S. Greene St, 2nd Floor, Baltimore MD 21201

31. Date filed (Month, Day, Year)

MAY 30 1996

32. Registrar's Signature

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
correctly filled in by the funeral director, page 2 should be detached for use as the burial-transit
certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 15941


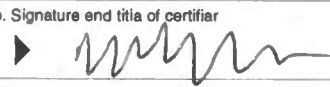

Certificate of Death

Item: 1, per F.H. G-735 5/30/96 reb

Reg. No.

Physician
/Medical
Examiner

Funeral
Director

| | | | | | |
|--|---------------------------------|--|--|---|--|
| 1. Decedent's Name (First, Middle, Last)
BABY BOY REILLY "B" MATTHEW FRANCIS REILLY | | 2. Date of Death
Month Day Year
MAY 26, 1996 | | 3. Time of Death
7:38 PM | |
| 4a. Facility Name (If not institution, give street and number)
SAINT JOSEPH MEDICAL CENTER | | 4b. City, Town, or Location of Death
TOWSON, MD. | | 4c. County of Death
BALTIMORE | |
| 5. Social Security Number
N/A | 6. Sex
1 M 2 F | 7. Age (In yrs. last birthday)
Yrs.
8 | 8. Date of Birth (Month, Day, Year)
May 18, 1996 | 9. Birthplace (State or Foreign Country)
Maryland | |
| Usual Residence of Decedent | | | | | |
| 10a. State
Maryland | 10b. County
Baltimore | 10c. City, Town or Location
Parkville | | 10d. Inside City Limits
1 Y 2 N | |
| 10e. Street and Number
2907 Harview Avenue | | 10f. Zip Code
21234 | | 10g. Citizen of What Country?
United States | |
| 11. Marital Status
1 X Never Married 2 Married 3 Widowed 4 Divorced | | 12. Was Decedent Ever In U.S. Armed Forces?
1 Yes 2 X No | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No)
1 Yes 2 X No | |
| 15. Decedent's Education (Specify only highest grade completed)
N/A | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Dependent | | 16b. Kind of Business/Industry
N/A | |
| 17. Father's Name (First, Middle, Last)
James Thomas Reilly | | 18. Mother's Name (First, Middle, Maiden Surname)
Theresa Lynn Mechura | | | |
| 19a. Informant's Name/Relationship (Type, Print)
Mr. James T. Reilly | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
2907 Harview Avenue Parkville, MD 21234 | | | |
| 20a. Method of Disposition
1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
St. Joseph Church Cem. | | 20c. Location - City or Town, State
Fullerton, Maryland | |
| 21. Signature of Funeral Service Licensee
 | | 22. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222 | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | |
| Immediate Cause (Final disease or condition resulting in death) | | a. NECROTIZING ENTEROCOLITIS | | 1 DAY | |
| | | b. PREMATURITY | | 8 DAYS | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | c. | | | |
| | | d. | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | |
| 23b. Did tobacco use contribute to the cause of death?
1 Yes 2 X No 3 Probably 4 Unknown | | | | | |
| 24a. Was an autopsy performed?
1 Yes 2 X No | | 24b. Were autopsy findings available prior to completion of cause of death?
1 Yes 2 X No | | | |
| 25. Was case referred to medical examiner?
1 Yes 2 X No | | 26. Place of Death (Check only one)
Hospital: 1 X Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) | | | |
| 27. Manner of Death
1 X Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | |
| | | 28c. Injury at Work?
1 Yes 2 No | | 28d. Describe how injury occurred | |
| | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. Certifier (Check only one)
1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | |
| 29b. Signature and title of certifier
 | | 29c. License number
D41343 | | 29d. Date signed (Month, Day, Year)
05/26/96 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
DR. MICHAEL LANGBAUM M.D., 7620 YORK ROAD, TOWSON, MD. 21204 | | | | | |
| 31. Date filed (Month, Day, Year)
MAY 30 1996 | | 32. Registrar's Signature
 | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020
perm. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 23a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Division of Vital Records, P.O. Box 68760,

State
Registrar

3. 4. 5. 6. 7. 8. 9. 10. 11. 12. 13. 14. 15. 16. 17. 18. 19. 20. 21. 22. 23. 24. 25. 26. 27. 28. 29. 30. 31. 32. 33. 34. 35. 36. 37. 38. 39. 40. 41. 42. 43. 44. 45. 46. 47. 48. 49. 50. 51. 52. 53. 54. 55. 56. 57. 58. 59. 60. 61. 62. 63. 64. 65. 66. 67. 68. 69. 70. 71. 72. 73. 74. 75. 76. 77. 78. 79. 80. 81. 82. 83. 84. 85. 86. 87. 88. 89. 90. 91. 92. 93. 94. 95. 96. 97. 98. 99. 100.

3

101. 102. 103. 104. 105. 106. 107. 108. 109. 110. 111. 112. 113. 114. 115. 116. 117. 118. 119. 120. 121. 122. 123. 124. 125. 126. 127. 128. 129. 130. 131. 132. 133. 134. 135. 136. 137. 138. 139. 140. 141. 142. 143. 144. 145. 146. 147. 148. 149. 150. 151. 152. 153. 154. 155. 156. 157. 158. 159. 160. 161. 162. 163. 164. 165. 166. 167. 168. 169. 170. 171. 172. 173. 174. 175. 176. 177. 178. 179. 180. 181. 182. 183. 184. 185. 186. 187. 188. 189. 190. 191. 192. 193. 194. 195. 196. 197. 198. 199. 200.

201. 202. 203. 204. 205. 206. 207. 208. 209. 210. 211. 212. 213. 214. 215. 216. 217. 218. 219. 220. 221. 222. 223. 224. 225. 226. 227. 228. 229. 230. 231. 232. 233. 234. 235. 236. 237. 238. 239. 240. 241. 242. 243. 244. 245. 246. 247. 248. 249. 250. 251. 252. 253. 254. 255. 256. 257. 258. 259. 260. 261. 262. 263. 264. 265. 266. 267. 268. 269. 270. 271. 272. 273. 274. 275. 276. 277. 278. 279. 280. 281. 282. 283. 284. 285. 286. 287. 288. 289. 290. 291. 292. 293. 294. 295. 296. 297. 298. 299. 300.

96 15942

Film G735 item 0c per FH 5-30-96 rja

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|--|---|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last)
Melvin J. Schaefer | | | | 2. DATE OF DEATH
MONTH DAY YEAR
May 14 1996 | | 3. TIME OF DEATH
7:15 AM | |
| 4. SOCIAL SECURITY NUMBER
215-01-5071 | | 5. SEX
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
82 YRS. | | 7. DATE OF BIRTH
(Month, Day, Year)
Jan. 7, 1914 | |
| 8. BIRTHPLACE (State or Foreign Country)
Maryland | | 9a. FACILITY NAME (If not institution, give street and number)
Good Samaritan Nursing Ctr. | | 9b. CITY, TOWN OR LOCATION OF DEATH
Baltimore, Maryland | | 9c. COUNTY OF DEATH
Baltimore | |
| 10a. STATE
Maryland | | 10b. COUNTY
Baltimore | | 10c. CITY, TOWN OR LOCATION
Essex | | 10d. INSIDE CITY LIMITS?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 10e. STREET AND NUMBER
2030 Sue Creek Drive | | | | 10f. ZIP CODE
21221 | | 10g. CITIZEN OF WHAT COUNTRY?
USA | |
| 11. MARITAL STATUS
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?
1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO
IF YES, GIVE WAR OR DATES
W WWII | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify: White | |
| 15. DECEDENT'S EDUCATION
(Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (14 or 5+) 3 | | 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.)
Salesman | | 16b. KIND OF BUSINESS/INDUSTRY
Jewelry | | | |
| 17. FATHER'S NAME (First, Middle, Last)
Henry Schaefer | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Alverta Croswell | | | |
| 19a. INFORMANT'S NAME (Type/Print)
Marilyn Reinhardt | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
2439 Hughes Shop Rd., Westminster, MD 21158 | | | |
| 20a. METHOD OF DISPOSITION
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
Dulaney Valley Mem Gardens | | 20c. LOCATION — City or Town, State
May 17 Timonium | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
Bryan W. Clary | | | | 22. NAME AND ADDRESS OF FACILITY
Lemon Funeral Home of Dulaney Valley
10 W. Padonia Rd., Timonium, MD 21093 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

IMMEDIATE CAUSE (Final disease or condition resulting in death) →

Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

a. <u>SEPSIS</u>
DUE TO (OR AS A CONSEQUENCE OF):
b. <u>gangrene of leg</u>
DUE TO (OR AS A CONSEQUENCE OF):
c. <u>peripheral vascular disease</u>
DUE TO (OR AS A CONSEQUENCE OF):
d. | | | | | | | Approximate Interval Between Onset and Death |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | 24a. WAS AN AUTOPSY PERFORMED?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |
| 26. PLACE OF DEATH (Check only one)
1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA
4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | 27. MANNER OF DEATH
<input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation
2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined
3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Homicide 8 <input type="checkbox"/> Other (Specify) | | | | | |
| 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M | | 28c. INJURY AT WORK?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURED | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one)
<input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
Jeffrie Cool | | | | 29c. LICENSE NUMBER
D34650 | | 29d. DATE SIGNED (Month, Day, Year)
5-15-96 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
Jeffrie Cool, M.D. 9712 Belair Rd. Suite 203 Balto, MD 21236 | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
MAY 30 1996 | | | | 32. REGISTRAR'S SIGNATURE
Julia Davidson-Randall | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 8 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 7 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

96 15943

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|--|--------------------------------|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
Harry Shiffman | | | | 2. DATE OF DEATH
MONTH DAY YEAR
May 24 1996 | | 3. TIME OF DEATH
12:40 P M | |
| 4. SOCIAL SECURITY NUMBER
218-01-1431 | | 5. SEX
1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | 6. AGE (In yrs. last birthday)
82 YRS. | IF UNDER 1 YEAR
MONTHS DAYS | IF UNDER 24 HRS.
HOURS MIN. | 7. DATE OF BIRTH (Month, Day, Year)
JAN. 2, 1914 | |
| 8. BIRTHPLACE (State or Foreign Country)
MARYLAND | | | | 9a. FACILITY NAME (If not institution, give street and number)
Riverview Nursing Centre, Inc. | | 9b. CITY, TOWN OR LOCATION OF DEATH
ESSEX | |
| 9c. COUNTY OF DEATH
BALTIMORE | | | | 10a. STATE
MARYLAND | | 10b. COUNTY
BALTIMORE | |
| 10c. CITY, TOWN OR LOCATION
BALTIMORE | | | | 10d. INSIDE CITY LIMITS?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 10e. STREET AND NUMBER
1715 ABERDEEN ROAD | |
| 10f. ZIP CODE
21234 | | | | 10g. CITIZEN OF WHAT COUNTRY?
USA | | 11. MARITAL STATUS
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify: WHITE | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (1-4 or 5+) College | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
DRIVER | | 16b. KIND OF BUSINESS/INDUSTRY
TAXI | |
| 17. FATHER'S NAME (First, Middle, Last)
MEYER | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
RESA HARANSKY | | | |
| 19a. INFORMANT'S NAME (Type/Print)
MRS. PAT TATAR (STEP-DAUGHTER) | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
902 KINGSTON ROAD BALTIMORE, MD 21212 | | | |
| 20a. METHOD OF DISPOSITION
1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
DRUID RIDGE | | 20c. LOCATION — City or Town, State
5-29-1996- PIKESVILLE, MD | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
<i>Michael Schwartz</i> | | | | 22. NAME AND ADDRESS OF FACILITY
SOL LEVINSON & BROS., INC.
8900 REISTERSTOWN ROAD PIKESVILLE, MD 21208 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Left louverail
DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| b. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| c. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| d. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Alzheimer's Disease | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DDA
OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | |
| 27. MANNER OF DEATH
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation
2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 6 <input type="checkbox"/> Could not be determined
4 <input type="checkbox"/> Homicide | | | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M | |
| 28c. INJURY AT WORK?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | 28d. DESCRIBE HOW INJURY OCCURRED | | | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one)
1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
<i>Michael Schwartz</i> | | | | 29c. LICENSE NUMBER
D19667 | | 29d. DATE SIGNED (Month, Day, Year)
5/24/96 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
DR. MICHAEL SCHWARTZ HAMMONDS LANE 21225 | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
MAY 30 1996 | | | | 32. REGISTRAR'S SIGNATURE
<i>John A. Anderson</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 9 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 15944

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Mary Irene Scally

2. Date of Death

Month Day Year
May 24, 1996

3. Time of Death

11:00 AM

4a. Facility Name (If not institution, give street and number)

2722 Cheswolde Road

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

Funeral
Director

5. Social Security Number

217-20-4465

6. Sex

☐ M ☒ F

7. Age (In yrs. last birthday)

89

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
May 4, 1907

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

N/A

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

2722 Cheswolde Rd.

10f. Zip Code

21209

10g. Citizen of What Country?

USA

11. Marital Status

☒ Never Married ☐ Married
☐ Widowed ☐ Divorced

12. Was Decedent Ever In U.S.

Armed Forces?
☐ Yes ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)☐ Yes ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: WHITE

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

5+

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Teacher

16b. Kind of Business/Industry

Education

17. Father's Name (First, Middle, Last)

Lawrence Theodore Scally

18. Mother's Name (First, Middle, Maiden Surname)

Margaret Byrne

19a. Informant's Name/Relationship (Type, Print)

Helen S. Beck

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

8424 B Charles Valley Court, Towson, MD 21204

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State
☐ Donation ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

St. Joseph's Cemetery

Date

28
MAY

20c. Location - City or Town, State

Cockeysville, MD

21. Signature of Funeral Service Licensee

Bryan W. Clary

22. Name and Address of Facility

Lemmon Funeral Home of Dulaney Valley, Inc.
10 W. Padonia Rd., Timonium, MD 2109323a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)e. cardiac arrest
Due to (or as a consequence of):b. Atherosclerotic Heart Disease
Due to (or as a consequence of):c. Cardiac arrhythmias
Due to (or as a consequence of):

d. CHF

Approximate
Interval Between
Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending Investigation
6 ☐ Could not be determined28a. Date of Injury
(Month, Day Year)28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

29c. License number

D17803

29d. Date signed (Month, Day, Year)

5-24-96

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Warren Israel, M.D. Ruxton Tower Apartments, Towson, Maryland 21204

31. Date filed (Month, Day, Year)

MAY 30 1996

32. Registrar's Signature

Julia Davidson-Robert

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene **96 15945**
Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last) **Katherine Sittenham** 2. Date of Death Month **May** Day **25** Year **1996** 3. Time of Death **3:30 pm**

Funeral
Director

4a. Facility Name (If not institution, give street and number) **Stella Maris** 4b. City, Town, or Location of Death **Towson** 4c. County of Death **Baltimore**

5. Social Security Number **220-40-8045** 6. Sex ☐ M ☒ F 7. Age (In yrs. last birthday) **92** Yrs. If Under 1 Year Months Days If Under 24 Hrs. Hours Min. 8. Date of Birth (Month, Day, Year) **June 30, 1903** 9. Birthplace (State or Foreign Country) **Illinois**

Usual Residence of Decedent 10a. State **Maryland** 10b. County **Baltimore** 10c. City, Town or Location **Towson** 10d. Inside City Limits ☐ Yes ☒ No

10e. Street and Number **2300 Dulaney Valley Road** 10f. Zip Code **21204** 10g. Citizen of What Country? **USA**

11. Marital Status ☐ Never Married ☐ Married ☒ Widowed ☐ Divorced 12. Was Decedent Ever in U.S. Armed Forces? ☐ Yes ☒ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) ☐ Yes ☒ No Specify: 14. Race - American Indian, Black, White, etc. Specify: **White**

15. Decedent's Education (Specify only highest grade completed) **Elementary/Secondary (0-12)** **12** 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) **Housewife-Homemaker** 16b. Kind of Business/Industry **Own Home**

17. Father's Name (First, Middle, Last) **Fred Bassinger** 18. Mother's Name (First, Middle, Maiden Surname) **Mary McGraw**

19a. Informant's Name/Relationship (Type, Print) **Helene S. Thomson** 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) **746 Camberley Cir., Towson, Maryland 21204**

20a. Method of Disposition ☒ Burial ☐ Cremation ☐ Removal from State ☐ Donation ☐ Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place) **Moreland Mem. Park.** Date **May 29** 20c. Location - City or Town, State **Parkville, Maryland**

21. Signature of Funeral Service Licensee **Bryan W. Clary** 22. Name and Address of Facility **Lemmon Funeral Home** **10 W. Padonia Road, Timonium, MD 21093**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death) a. **Acute Myocardial Infarction** Due to (or as a consequence of):
 b. Due to (or as a consequence of):
 c. Due to (or as a consequence of):
 d. **Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last**

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? ☐ Yes ☐ No ☐ Probably ☒ Unknown

24a. Was an autopsy performed? ☐ Yes ☒ No 24b. Were autopsy findings available prior to completion of cause of death? ☐ Yes ☐ No

25. Was case referred to medical examiner? ☒ Yes ☐ No 26. Place of Death (Check only one) Hospital: ☐ Inpatient ☐ ER/Outpatient ☐ DOA Other: ☒ Nursing Home ☐ Residence ☐ Other (Specify)

27. Manner of Death ☒ Natural ☐ Accident ☐ Suicide ☐ Homicide ☐ Pending investigation ☐ Could not be determined 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury M 28c. Injury at Work? ☐ Yes ☐ No 28d. Describe how Injury occurred 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier 29c. License number **15504** 29d. Date signed (Month, Day, Year) **5-28-96**

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) **Eddie Nakhuda, M.D.** **2300 Dulaney Valley Road, Baltimore, Maryland 21204**

31. Date filed (Month, Day, Year) **MAY 30 1996**

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 15946

Certificate of Death

Reg. No.

| | | | | | | | | |
|--|--|--|---|--|---|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
GERALDINE M. SHAPIRO | | | | 2. Date of Death
May 21, 1996 Year | | 3. Time of Death
2:00AM | |
| | 4a. Facility Name (If not institution, give street and number)
Washington Adventist Hospital | | | | 4b. City, Town, or Location of Death
Takoma Park | | 4c. County of Death
Montgomery | |
| Funeral
Director | 5. Social Security Number
559-10-6596 | | 6. Sex
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday)
77 Yrs. | | 8. Date of Birth (Month, Day, Year)
June 24, 1918 | |
| | 9. Birthplace (State or Foreign Country)
California | | 10a. State
Maryland | | 10b. County
Montgomery | | 10c. City, Town or Location
Bethesda | |
| To Be Completed by Funeral Director | 10d. Inside City Limits
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 10e. Street and Number
8130 Wisconsin Avenue | | 10f. Zip Code
20815 | | 10g. Citizen of What Country?
U.S.A. | |
| | 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: White | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (1-4 or 5+) College | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Homemaker | | 16b. Kind of Business/Industry
own home | | | |
| | 17. Father's Name (First, Middle, Last)
Unavailable | | 18. Mother's Name (First, Middle, Maiden Surname)
Unavailable | | | | | |
| | 19a. Informant's Name/Relationship (Type, Print)
Michael Shapiro | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Perry Point Med. Cntr., Unit 14B, Md. 21902 | | | | | |
| | 20a. Method of Disposition
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Rock Creek Cemetery 5-24-96 | | 20c. Location - City or Town, State
Washington, DC | | | |
| | 21. Signature of Funeral Service Licensee
Lisa D. Williams | | 22. Name and Address of Facility
Ives-Pearson Funeral Homes
Falls Church, Va. 22046 | | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

a. ACUTE DIFFUSE INTERSTITIAL PNEUMONITIS 1 wk.
Dua to (or as a consequence of):

b. RIGHT BREAST CANCER - STAGE 3 3-6 mos.
Dua to (or as a consequence of):

c. HYPoxic ENCEPHALOPATHY 1 wk.
Dua to (or as a consequence of):

d. | | Approximate Interval Between Onset and Death | | | | | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
1) DEMENTIA | | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | |
| | 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> OOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year)
M | |
| 28b. Time of Injury
M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | | 28e. Location (Street and Number or Rural Route Number, City or Town, State) | | |
| 29a. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier
ATTENDING
Nelson - PHYSICIAN | | 29c. License number
D 43869 | | 29d. Date signed (Month, Day, Year)
MAY 21, 1996 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
11908 DARNESTOWN RD., SUITED, NORTH POTOMAC, MD 20878. | | 31. Date filed (Month, Day, Year)
MAY 30 1996 | | 32. Registrar's Signature
Julia Davidson-Rendell | | | | |

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 15947

Certificate of Death

Reg. No.

| | | | | | | | | |
|--|--|--|---|---|---|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
WILLIAM N. SPEARMAN | | | | 2. Date of Death
Month Day Year
MAY 27, 1996 | | 3. Time of Death
5:38 PM. | |
| | 4a. Facility Name (If not institution, give street and number)
1529 W. FAYETTE ST. | | | | 4b. City, Town, or Location of Death
BALTIMORE | | 4c. County of Death
n/a | |
| Funeral
Director | 5. Social Security Number
231-16-0444 | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)
74 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth (Month, Day, Year)
Aug 24, 1921 | 9. Birthplace (State or Foreign Country)
North Carolina |
| | Usual Residence of Decedent | | | | | | | |
| To Be Completed by Funeral Director | 10a. State
MD | | 10b. County
n/a | | 10c. City, Town or Location
Baltimore | | | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |
| | 10e. Street and Number
1529 West Fayette Street | | | | 10f. Zip Code
21223 | | 10g. Citizen of What Country?
USA | |
| | 11. Marital Status
<input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: Black | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) Jr. High School
College (1-4or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Assembly Worker | | 16b. Kind of Business/Industry
General Motors | |
| | 17. Father's Name (First, Middle, Last)
Lloyd Spearman | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Alice Wright | | | |
| | 19a. Informant's Name/Relationship (Type, Print)
Mittie McPhaul | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
4002 Clifton Avenue Baltimore, MD 21216 | | | |
| | 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Cedar Hill Cemetery | | Date
June 1 | 20c. Location - City or Town, State
Baltimore, Maryland | | |
| | 21. Signature of Funeral Service Licensee
Herbert E. Nutter | | | | 22. Name and Address of Facility
Nutter Funeral Homes, Inc.
2501 Gwynns Falls Parkway
Baltimore, Maryland 21216 | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
Immediate Cause (Final disease or condition resulting in death)
ATHEROSCLEROTIC CARDIOVASCULAR DISEASE
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. | | | | | | | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | |
| Physician
/Medical
Examiner | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown | | | | 24e. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | |
| | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | |
| | 25. Was case referred to medical examiner?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | 26. Place of Death (Check only one)
Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | |
| | 27. Manner of Death
1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation
2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined
3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| | 28d. Describe how injury occurred | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| Medical Certification: To Be Completed by Physician/Medical Examiner | 29a. Certifier (Check only one)
1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | |
| | 29b. Signature and title of certifier
Korwin A. Korwin | | | | 29c. License number
O.C.M.E. | | 29d. Date signed (Month, Day, Year)
MAY 28, 1996 | |
| | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Korwin A. Korwin 111 Penn Street, Baltimore, Maryland 21201 | | | | | | | |
| State Registrar | 31. Date filed (Month, Day, Year)
MAY 30 1996 | | | | 32. Registrar's Signature
Julia Anderson-Randall | | | |

Baltimore, Maryland 21215-0020
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,
To the Hospital or Attending Physician: The last certifier that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 15948

Certificate of Death

Reg. No.

| | | | | | | | |
|--|--|---|---|---|--|---|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
ROLAND R. SCOTT | | | 2. Date of Death
Month MAY Day 14 Year 1996 | | 3. Time of Death
3P.M. | |
| | 4a. Facility Name (If not institution, give street and number)
5124 QUEENSBERRY AVE. | | | 4b. City, Town, or Location of Death
BALTIMORE | | 4c. County of Death
CITY | |
| Funeral
Director | 5. Social Security Number
214-68-2805 | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)
Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth
(Month, Day, Year)
1/15/1956 |
| | Usual Residence of Decedent | | 9. Birthplace (State or Foreign Country)
BALTIMORE, MD. | | | | |
| To Be Completed by Funeral Director | 10a. State
MARYLAND | | 10b. County | | 10c. City, Town or Location
BALTIMORE | | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |
| | 10e. Street and Number
5124 QUEENSBERRY AVE. | | | 10f. Zip Code
21215 | | 10g. Citizen of What Country?
USA | |
| | 11. Marital Status
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify:
ARFO. AMERICAN |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (1-4 or 5+) 0 | | 18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
MAINTENANCE MAN | | 16b. Kind of Business/Industry
BLAKE'S LAWN CO. | | |
| | 17. Father's Name (First, Middle, Last)
JOHN T. SCOTT | | | 18. Mother's Name (First, Middle, Maiden Surname)
BETTY HICKS | | | |
| | 19a. Informant's Name/Relationship (Type, Print)
BETTY COE | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
6641 DALTON DR. BALTIMORE, MARYLAND 21207 | | | |
| | 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
WOODLAWN CEMETERY | | Date
5/20/96 | | 20c. Location - City or Town, State
BALTIMORE, MARYLAND |
| | 21. Signature of Funeral Service Licensee
<i>[Signature]</i> | | | 22. Name and Address of Facility
ESTEP BROTHERS FUNERAL HOME, P.A.
1300 EUTAW PLACE, BALTIMORE, MARYLAND 21217 | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or head failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. AIDS
Due to (or as a consequence of):

b.
Due to (or as a consequence of):

c.
Due to (or as a consequence of):

d. | | | | | | |
| | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | | |
| 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
CHE, Encephalitis, TB | | | | | | | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28d. Describe how Injury occurred | | | |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29e. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. Signature and title of certifier
<i>[Signature]</i> | | | 29c. License number
D36353 | | 29d. Date signed (Month, Day, Year)
5/16/96 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
4120 Patterson Ave Baltimore MD 21215 | | | | | | | |
| 31. Date filed (Month, Day, Year)
MAY 30 1996 | | 32. Registrar's Signature
<i>[Signature]</i> | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

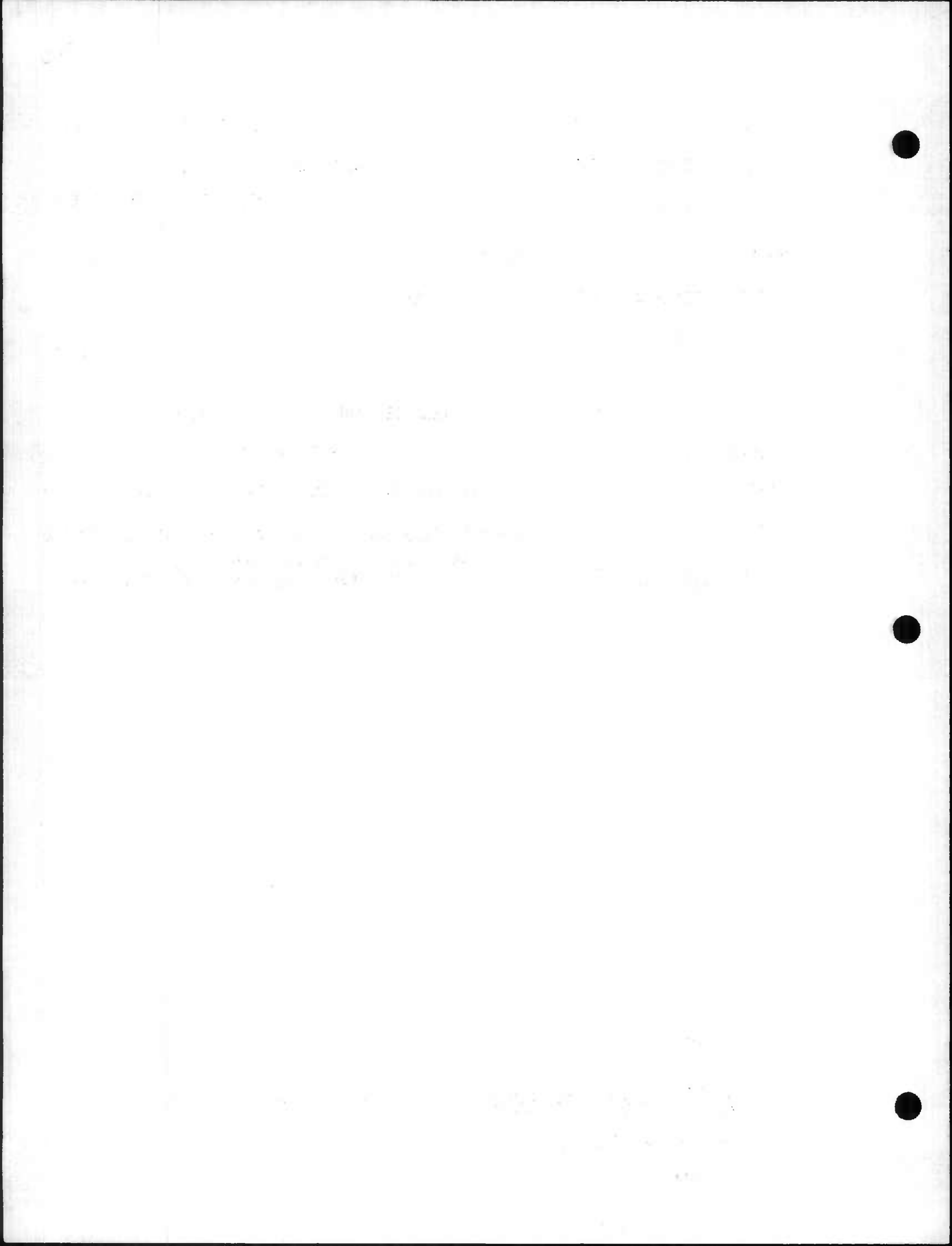
Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar



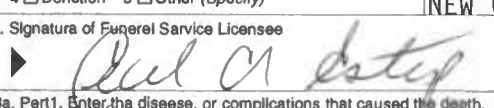
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 15949

Certificate of Death

Reg. No.

| | | | | | | | | | | | |
|---|--|--|---|--|--|---------------------------------|--|---|--|---|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
BEATRICE E. SNOWDEN | | | | | | 2. Date of Death
Month 5 Day 21 Year 96 | | 3. Time of Death
1:53 Am | | |
| | 4a. Facility Name (If not institution, give street and number)
(HOME) 1600 MT. ROYAL AVE, APT. 1505 | | | | | | 4b. City, Town, or Location of Death
BALTIMORE | | 4c. County of Death
BALTO. CITY | | |
| Funeral
Director | 5. Social Security Number
164 12 8378 | | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)
80 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth (Month, Day, Year)
11/22/15 | | 9. Birthplace (State or Foreign Country)
MD. | | |
| | Usual Residence of Decedent | | | | | | | | | | |
| To Be Completed by Funeral Director | 10a. State
MD. | | 10b. County
BALTO. CITY | | 10c. City, Town or Location
BALTIMORE | | | | 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| | 10e. Street and Number
1600 MT. ROYAL AVE. APT. 1505 | | | | 10f. Zip Code
21217 | | 10g. Citizen of What Country?
USA | | | | |
| | 11. Marital Status
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc.
Specify: BLACK | | | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (1-4 or 5+) 0 | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
HOMEMAKER | | | 16b. Kind of Business/Industry
HOME | | | |
| | 17. Father's Name (First, Middle, Last) | | | | | | 18. Mother's Name (First, Middle, Maiden Surname)
ANNIE F. DOUGLAS | | | | |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print)
SHIRLEY ROBINSON DAUGHTER | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1600 MT. ROYAL AVE, BALTO. MD. 21217 APT. 1505 | | | | | | |
| | 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
NEW CATHEDRAL | | Date
5/25/96 | | 20c. Location - City or Town, State
BALTIMORE, MD. | | |
| | 21. Signature of Funeral Service Licensee
 | | | | 22. Name and Address of Facility
ESTEP BROTHERS FUNERAL HOME P.A.
1300 EUTAW PL. BALTIMORE, MD. 21217 | | | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

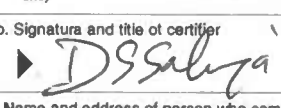

Immediate Cause (Final disease or condition resulting in death)

a. <u><i>Congestive Heart Failure</i></u>
Due to (or as a consequence of):

b. <u><i>Atherosclerotic Cardiovascular Disease</i></u>
Due to (or as a consequence of):

c. _____
Due to (or as a consequence of):

d. _____

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | | | | |
| | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
<u><i>History of Meningioma Brain</i></u> | | | | | | | | | | | |
| 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | | | | |
| 25. Was case referred to medical examiner?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | | | | | |
| 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation
<input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined
<input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | 29b. Signature and title of certifier
 | | | | 29c. License number
D 17537 | | 29d. Date signed (Month, Day, Year)
5-23-96 | |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)
DARSHAN S. SALUJA MD 1600 W. MOUNT ROYAL AVE, Baltimore MD 21217 | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
MAY 30 1996 | | | | | | | | | | | |
| 32. Registrar's Signature
 | | | | | | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 15950

Certificate of Death

Reg. No.

| | | | | | | | | |
|---|---|--|---|---|--|--|---|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
CHARLES STEWART | | | | 2. Date of Death
Month Day Year
MAY 27, 1996 | | 3. Time of Death
14:14 | |
| | 4a. Facility Name (If not Institution, give street and number)
THE JOHNS HOPKINS HOSPITAL | | | | 4b. City, Town, or Location of Death
BALTIMORE CITY | | 4c. County of Death
BALTIMORE CITY | |
| Funeral
Director | 5. Social Security Number
409-20-7867 | 8. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)
70 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth (Month, Day, Year)
AUGUST 27, 1925 | | 9. Birthplace (State or Foreign Country)
WEST VIRGINIA |
| | Usual Residence of Decedent | | | | | | | |
| To Be Completed by Funeral Director | 10a. State
MD | 10b. County
BALTO. CITY | 10c. City, Town or Location
BALTIMORE | | | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | |
| | 10e. Street and Number
714 N. PORT STREET | | | 10f. Zip Code
21205 | | 10g. Citizen of What Country?
UNITED STATES | | |
| | 11. Marital Status
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: BLACK | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (1-4 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
LABORER | | | 16b. Kind of Business/Industry
WHOLESALE PRODUCE | | |
| | 17. Father's Name (First, Middle, Last)
WILLIAM SMITH | | | | 18. Mother's Name (First, Middle, Maiden Surname)
BERTHA LEE | | | |
| To Be Completed by Physician/Medical Examiner | 19e. Informant's Name/Relationship (Type, Print)
MILDRED STEWART - WIFE | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
714 N. PORT STREET BALTO, MD 21205 | | | |
| | 20e. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
KING MEM. PK | | Date
5/31/96 | | 20c. Location - City or Town, State
RANDALLSTOWN, MD | |
| | 21. Signature of Funeral Service Licensee
<i>Calvin L. Williams</i> | | | | 22. Name and Address of Facility
CALVIN L. WILLIAMS F.S. 270 FRED HILTON PASS BALTO., MD 21229 | | | |
| | 23e. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. CEREBROVASCULAR ACCIDENT
Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | Approximate Interval Between Onset and Death
3 DAYS |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
ATHEROSCLEROTIC DISEASE | | | | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one)
Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how Injury occurred |
| | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | |
| 29e. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and Title of certifier
<i>David F. Kong MD</i> DAVID F. KONG MD | | 29c. License number
P08016 | | 29d. Date signed (Month, Day, Year)
MAY 27, 1996 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
DAVID F. KONG MD 700 North Wolfe Street Baltimore | | | | | | | | |
| 31. Date filed (Month, Day, Year)
MAY 30 1996 | | 31. Date filed (Month, Day, Year)
MAY 30 1996 | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760

1. The first part of the report deals with the general situation of the country and the progress of the work during the year. It is divided into two main sections: the first section deals with the general situation and the second section deals with the progress of the work.

2. The second part of the report deals with the results of the work during the year. It is divided into two main sections: the first section deals with the results of the work in the field and the second section deals with the results of the work in the laboratory.

3. The third part of the report deals with the conclusions of the work during the year. It is divided into two main sections: the first section deals with the conclusions of the work in the field and the second section deals with the conclusions of the work in the laboratory.

4. The fourth part of the report deals with the recommendations of the work during the year. It is divided into two main sections: the first section deals with the recommendations of the work in the field and the second section deals with the recommendations of the work in the laboratory.

5. The fifth part of the report deals with the summary of the work during the year. It is divided into two main sections: the first section deals with the summary of the work in the field and the second section deals with the summary of the work in the laboratory.

96 15951

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
Anna Josephine Smith | | | | 2. DATE OF DEATH
MONTH DAY YEAR
May 23, 1996 | | 3. TIME OF DEATH
6:30 P.M. | |
| 4. SOCIAL SECURITY NUMBER
219-38-8106 | | 5. SEX
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
87 YRS. | | 7. DATE OF BIRTH (Month, Day, Year)
Nov. 24, 1908 | |
| 8. BIRTHPLACE (State or Foreign Country)
Balto. City, Md. | | | | 9a. FACILITY NAME (If not institution, give street and number)
Cardinal Shehan Center | | 9b. CITY, TOWN OR LOCATION OF DEATH
Towson | |
| 9c. COUNTY OF DEATH
Baltimore Co. | | | | 10a. STATE
Maryland | | | |
| 10b. COUNTY
Baltimore Co. | | | | 10c. CITY, TOWN OR LOCATION
Cockeysville | | | |
| 10d. INSIDE CITY LIMITS?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | 10e. STREET AND NUMBER
12 G Beehive Place | | | |
| 10f. ZIP CODE
21030 | | | | 10g. CITIZEN OF WHAT COUNTRY?
United States | | | |
| 11. MARITAL STATUS
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12) 09 College (1-4 or 5+) | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
Assistant Dietitian | | 16b. KIND OF BUSINESS/INDUSTRY
Hospital | |
| 17. FATHER'S NAME (First, Middle, Last)
Frank J. Shaller | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Catherine Bauer | | | |
| 19a. INFORMANT'S NAME (Type/Print)
David C. Smith (Grandson) | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1042 Saxon Hill Drive Cockeysville, Maryland 21030 | | | |
| 20a. METHOD OF DISPOSITION
1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
Hilltop Service Corp. 5/24/96 | | 20c. LOCATION — City or Town, State
Towson, Maryland 21204 | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
Jeffrey L. Gair | | | | 22. NAME AND ADDRESS OF FACILITY
Ruck Towson Funeral Home, Inc.
1050 York Road Towson, Maryland 21204 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Myocardial Infarction
DUE TO (OR AS A CONSEQUENCE OF):
b. DUE TO (OR AS A CONSEQUENCE OF):
c. DUE TO (OR AS A CONSEQUENCE OF):
d. DUE TO (OR AS A CONSEQUENCE OF):
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
arthritis, Renarter | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA
OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation
2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined
3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M | | 28c. INJURY AT WORK?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | 29a. CERTIFIER (Check only one)
1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
Mark Stromberg | | | | 29c. LICENSE NUMBER
032543 | | 29d. DATE SIGNED (Month, Day, Year)
5/24/96 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
MARK Stromberg 7505 Osler Dr. | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
MAY 30 1996 | | | | 32. REGISTRAR'S SIGNATURE
John Davidson-Rodell | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 15952

Certificate of Death

Reg. No.

Physician
/Medical
ExaminerFuneral
Director

1. Decedent's Name (First, Middle, Last)

June R. Smith

2. Date of Death

May 23 1996

3. Time of Death

6:30 P.M.

4a. Facility Name (If not institution, give street and number)

Dulaney Towson Nursing Home

4b. City, Town, or Location of Death

Towson

4c. County of Death

Baltimore

5. Social Security Number

187-09-5577

8. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

80 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

Aug. 17, 1915

9. Birthplace (State or Foreign Country)

Md.

Usual Residence of Decedent

10a. State

Md.

10b. County

Baltimore

10c. City, Town or Location

Perry Hall

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

8820 Blairwood Rd.

10f. Zip Code

21236

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

8

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Sales

16b. Kind of Business/Industry

Sears Roebuck & Co.

17. Father's Name (First, Middle, Last)

Charles

Rhinehart

18. Mother's Name (First, Middle, Maiden Surname)

Lydia

Stevens

19a. Informant's Name/Relationship (Type, Print)

J. Stevens Smith

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

8820 Blairwood Rd. Apt. A-4 Perry Hall, Md. 21236

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Parkwood Cemetery

Date

5/28/96

20c. Location - City or Town, State

Parkville, Md.

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Ruck Towson Funeral Home, Inc.

1050 York Rd. Towson, Md. 21204

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. End Stage Renal Disease
Due to (or as a consequence of):b. Dehydration
Due to (or as a consequence of):c. Sepsis -
Due to (or as a consequence of):

d.

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28. Place of Death (Check only one)

Other:

4 ☒ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

5/28/96

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Bridget M. M. M., 30076 Northem Parkway, Baltimore, MD 21204

31. Date filed (Month, Day, Year)

MAY 30 1996

32. Registrar's Signature

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 15953

Certificate of Death

Reg. No.

| | | | | | | | | |
|--|---|---|---|--------------------------------------|--|--|---|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
WILLIE LEE SCALES | | | | 2. Date of Death
Month Day Year
MAY 24, 96 | | 3. Time of Death
7:41 P | |
| | 4a. Facility Name (If not institution, give street and number)
Gensis Nursing Home | | | | 4b. City, Town, or Location of Death
BALTO | | 4c. County of Death
MD | |
| Funeral
Director | 5. Social Security Number
422-30-8416 | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)
86 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth (Month, Day, Year)
Jul 28, 1909 | | 9. Birthplace (State or Foreign Country)
AL |
| | Usual Residence of Decedent | | | | | | | |
| To Be Completed by Funeral Director | 10a. State
MD | 10b. County
N/A | 10c. City, Town or Location
BALTO | | | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | |
| | 10e. Street and Number
1634 CARSWELL ST | | | 10f. Zip Code
21218 | | 10g. Citizen of What Country?
U.S.A | | |
| | 11. Marital Status
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: BLACK | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 7th College (1-4or 5+) N/A | | 16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
DOMESTIC | | 16b. Kind of Business/Industry
LAUNDRY | | | |
| | 17. Father's Name (First, Middle, Last)
WILL SMITH | | | | 18. Mother's Name (First, Middle, Maiden Surname)
NANCY UNKNOWN | | | |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print)
CLIFFORD SANDERS | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1634 CARSWELL ST BALTO, MD 21218 | | | |
| | 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
LIBERTY SPECIAL CARE | | 20c. Date
MAY 31, 1996 | | 20d. Location - City or Town, State
TUSCALOSSA, AL | |
| | 21. Signature of Funeral Service Licensee
 | | | | 22. Name and Address of Facility
BETTS FUNERAL HOME
1129 N. CAROLINE ST BALTO, MD 21213 | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. BRONCHITIS
Due to (or as a consequence of):
b. DYSPHAGIA
Due to (or as a consequence of):
c. STROKE
Due to (or as a consequence of):
d. DEMENTIA | | | | | | | |
| | Approximate Interval Between Onset and Death
5 days
3 MONTHS
1 YEAR
3 YEARS | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | |
| | | | | | | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred |
| | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier
 | | 29c. License number
D38950 | | 29d. Date signed (Month, Day, Year)
5/29/96 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
MANUEL RAMOS, MD 6800 YORK RD, BALTIMORE, MD 21212 | | | | | | | | |
| 31. Date filed (Month, Day, Year)
MAY 30 1996 | | 32. Registrar's Signature
 | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

State
Registrar

96 15954

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
James Sparks | | | | 2. DATE OF DEATH
MONTH DAY YEAR
MAY 23 1996 | | 3. TIME OF DEATH
19:55 PM | |
| 4. SOCIAL SECURITY NUMBER
212-10-5989 | | 5. SEX
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
85 YRS. | | 7. DATE OF BIRTH (Month, Day, Year)
JUN. 24, 1910 | |
| 9a. FACILITY NAME (If not institution, give street and number)
Union Memorial Hospital | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
Baltimore City | | 9c. COUNTY OF DEATH
N/A | |
| 10a. STATE
Maryland | | | | 10b. COUNTY
N/A | | 10c. CITY, TOWN OR LOCATION
Baltimore | |
| 10d. INSIDE CITY LIMITS?
<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | | | 10e. STREET AND NUMBER
3426 Erdman Avenue | | | |
| 10f. ZIP CODE
21213 | | | | 10g. CITIZEN OF WHAT COUNTRY?
United States | | | |
| 11. MARITAL STATUS
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify: Black | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)
5th | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
JANITOR | | 16b. KIND OF BUSINESS/INDUSTRY
MAINTENANCE | | | |
| 17. FATHER'S NAME (First, Middle, Last)
James Sparks | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Mary Sparks | | | |
| 19a. INFORMANT'S NAME (Type/Print)
Elizabeth Thornton | | | | 19b. MAILING ADDRESS (Route Number, City or Town, State, Zip Code)
4809 Kimberly Road, Baltimore, MD 21212 | | | |
| 20a. METHOD OF DISPOSITION
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
BALTIMORE CEMETERY | | 20c. LOCATION — City or Town, State
BALTIMORE, MARYLAND | | 20d. DATE
5-30 | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
Bernard D. Johnson | | | | 22. NAME AND ADDRESS OF FACILITY
Maftch Funeral Home
1101 E. North Avenue, Baltimore, MD 21202 | | | |
| 23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. METABOLIC ACIDOSIS | | | | | | | |
| DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| b. SEPSIS | | | | | | | |
| DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| c. Sequitally flat conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | |
| DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| d. | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Hypertension; Cardiomyopathy; Coronary Artery Disease; Acute Renal Failure | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED?
<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA
OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation
<input type="checkbox"/> Accident <input type="checkbox"/> Suicide
<input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M | | 28c. INJURY AT WORK?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one)
<input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
Paula Bennett MD | | | | 29c. LICENSE NUMBER
AT2438946 | | 29d. DATE SIGNED (Month, Day, Year)
MAY 23, 1996 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
PAULA BENNETT - UNION MEMORIAL HOSPITAL | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
MAY 30 1996 | | 32. REGISTRAR'S SIGNATURE
Julia Alexander-Randall | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

P.O. BOX 68760

DIVISION OF VITAL RECORDS

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 15955

Certificate of Death

Reg. No.

| | | | | | | | | |
|--|--|--|--|---|--|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Carson W. VIA | | | | 2. Date of Death
Month Day Year
May 28, 1996 | | 3. Time of Death
2:10 Am | |
| | 4a. Facility Name (If not Institution, give street and number)
1870 Marshall Road | | | | 4b. City, Town, or Location of Death
Dundalk | | 4c. County of Death
Baltimore | |
| Funeral
Director | 5. Social Security Number
227-03-4091A | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)
87 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth (Month, Day, Year)
01/28/1909 | | 9. Birthplace (State or Foreign Country)
VA. |
| | Usual Residence of Decedent | | | | | | | |
| 10a. State
MD. | | 10b. County
Baltimore | | 10c. City, Town or Location
Dundalk | | | 10d. Inside City Limits
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | |
| 10e. Street and Number
1870 Marshall Road | | | | 10f. Zip Code
21221 | | 10g. Citizen of What Country?
U.S.A. | | |
| 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc.
Specify: White | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 8th College (1-4or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Fork lift operator | | | 16b. Kind of Business/Industry
Manufacturing | |
| 17. Father's Name (First, Middle, Last)
Unobtainable | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Rosie Via | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
Alice Via/ Wife | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1870 Marshall Rd. Dundalk, MD. 21221 | | | | |
| 20a. Method of Disposition
1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Chesapeake Crematory | | Date
5-30-96 | 20c. Location - City or Town, State
Beltsville, MD. | | |
| 21. Signature of Funeral Service Licensee
 | | | | 22. Name and Address of Facility
Bradley-Ashton Funeral Home, Inc.
2134 Willow Spring Rd. Dundalk, MD. 21221 | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. Atherosclerotic cardiovascular disease
Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequitentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | | Approximate interval Between Onset and Death
years |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown | | |
| | | | | | | 24a. Was an autopsy performed?
<input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death?
<input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No |
| 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one)
Hospital: <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | |
| 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation
2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined
3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how Injury occurred |
| | | | | 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | |
| 29a. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | |
| 29b. Signature and title of certifier
 | | | | 29c. License number
D46163 | | 29d. Date signed (Month, Day, Year)
May 28, 1996 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Jude Muneses, M.D. 9000 Franklin Square Drive Baltimore, MD 21237 | | | | | | | | |
| 31. Date filed (Month, Day, Year)
MAY 3 01996 | | | | 32. Registrar's Signature
 | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 15956

Certificate of Death

Reg. No.

| | | | | | | | | | |
|--|---|---|---|---|--|---|--|---|---|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
ROBERT WAKE | | | | 2. Date of Death
Month 05 Day 27 Year 1996 | | 3. Time of Death
15:40 | | |
| | 4a. Facility Name (If not institution, give street and number)
SINAI HOSPITAL of BALTIMORE | | | | 4b. City, Town, or Location of Death
BALTIMORE CITY | | 4c. County of Death
BALTIMORE CITY | | |
| Funeral
Director | 5. Social Security Number
212-60-6915 | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)
41 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth (Month, Day, Year)
10/14/54 | 9. Birthplace (State or Foreign Country)
MD. | |
| | Usual Residence of Decedent | | | | 10a. State
MD | | 10b. County
N/A | | 10c. City, Town or Location
BALTIMORE |
| To Be Completed by Funeral Director | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | 10e. Street and Number
3325 W. GARRISON AVE. | | 10f. Zip Code
21215 | | 10g. Citizen of What Country?
US |
| | 11. Marital Status
<input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: BLK. | | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (1-4or 5+) 4 | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
COMPUTER OPERATOR | | 16b. Kind of Business/Industry
HEALTH CARE | | | | |
| | 17. Father's Name (First, Middle, Last)
EARL H. WAKE SR. | | | | 18. Mother's Name (First, Middle, Maiden Surname)
MURIEL BANKS | | | | |
| | 19a. Informant's Name/Relationship (Type, Print)
MURIEL ARMSTEAD (MOTHER) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
3325 W. GARRISON AVE. BALTIMORE, MD. 21215 | | | | |
| | 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
ARBUTUS MEM. PK. | | 20c. Location - City or Town, State
6/1/96 BALTIMORE, MARYLAND | | | | |
| | 21. Signature of Funeral Service Licensee
<i>[Signature]</i> CFSP #281 | | | | 22. Name and Address of Facility
PHILLIPS FUNERAL HOME
1721-27 N. MONROE ST. BALTIMORE, MD. 21217 | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | | Approximate Interval Between Onset and Death |
| | Immediate Cause (Final disease or condition resulting in death)
e. BLEEDING ESOPHAGEAL VARICES
Due to (or as a consequence of):
b. MOTOR VEHICLE ACCIDENT
Due to (or as a consequence of):
c. LIVER CIRRHOSIS
Due to (or as a consequence of):
d. LIVER LACERATION | | | | | | | | 3 DAYS
13 DAYS
2 YEARS
13 DAYS |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
ALCOHOL ABUSE, INTRAVENOUS HEROIN AND COCAINE ABUSE, HEPATITIS, RIGHT RIB FRACTURES, RIGHT TIBIA FRACTURE | | | | | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown
24a. Was an autopsy performed?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| 25. Was case referred to medical examiner?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA | | 26. Place of Death (Check only one)
Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. Manner of Death
<input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year)
05/14/96 | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred
MOTOR VEHICLE COLLISION | |
| 29a. Certifier (Check only one)
<input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier
<i>[Signature]</i> Paula Segal MD | | 29c. License number
AS2402321 PS9945 | | 29d. Date signed (Month, Day, Year)
MAY 29, 1996 | | | |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)
PIERRE CHEVRAY, SINAI HOSPITAL of BALTIMORE, 2401 W. BELVEDERE AVE, BALTO, MD 21215 | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
MAY 30 1996 | | 32. Registrar's Signature
<i>[Signature]</i> Wilson-Randall | | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

96 15957

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last)
Frances Wilson | | | | 2. DATE OF DEATH
MONTH May , DAY 14 , YEAR 1996 | | 3. TIME OF DEATH
3:20 P M | |
| 4. SOCIAL SECURITY NUMBER
219 38 3434 | | 5. SEX
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
55 YRS. | | 7. DATE OF BIRTH (Month, Day, Year)
1/28/41 | |
| 9a. FACILITY NAME (If not institution, give street and number)
Maryland General Hospital | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
Baltimore City | | 9c. COUNTY OF DEATH
Balto. City | |
| RESIDENCE OF DECEDENT | | | | 10c. CITY, TOWN OR LOCATION | | 10d. INSIDE CITY LIMITS?
<input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 10a. STATE
MD. | | 10b. COUNTY
BALTO. CITY | | BALTIMORE | | | |
| 10e. STREET AND NUMBER
3312 BURLEITH AVE. | | | | 10f. ZIP CODE
21215 | | 10g. CITIZEN OF WHAT COUNTRY?
USA | |
| 11. MARITAL STATUS
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify:
BLACK | |
| 15. DECEDENT'S EDUCATION
(Specify only highest grade completed)
Elementary/Secondary (0-12) 12
College (1-4 or 5+) 1 | | 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.)
BENEFIT CLERK | | 16b. KIND OF BUSINESS/INDUSTRY
S.S.A. | | | |
| 17. FATHER'S NAME (First, Middle, Last)
EARL CARTWELL | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
VIOLA CARTWELL | | | |
| 19a. INFORMANT'S NAME (Type/Print)
RHONDA WILSON Daughter | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
3312 BURLEITH AVE. BALTO. MD. 21215 | | | |
| 20a. METHOD OF DISPOSITION
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
ARBUTUS PARK 5/18/96 | | DATE
5/18/96 | | 20c. LOCATION — City or Town, State
ARBUTUS, MD. | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
<i>Carl A. Estep</i> | | | | 22. NAME AND ADDRESS OF FACILITY
ESTEP BROTHERS FUNERAL HOME P.A.
1300 EUTAW PL. BALTO. MD. 21217 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
IMMEDIATE CAUSE (Final disease or condition resulting in death) → Systemic Lupus
Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
a. DUE TO (OR AS A CONSEQUENCE OF):
Respiratory Failure
b. DUE TO (OR AS A CONSEQUENCE OF):
c. DUE TO (OR AS A CONSEQUENCE OF):
d. | | | | | | | Approximate interval Between Onset and Death |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | 24a. WAS AN AUTOPSY PERFORMED?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/> | | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA
OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation
2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined
3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M | | 28c. INJURY AT WORK?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. CERTIFIER (Check only one)
1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
<i>Melskaya</i> M.D. | | | | 29c. LICENSE NUMBER
89263 | | 29d. DATE SIGNED (Month, Day, Year)
5/14/96 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
Elisaveta Melskaya, M.D. c/o Maryland General Hospital | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
MAY 30 1996 | | | | 32. REGISTRAR'S SIGNATURE
<i>Julia Davidson-Randall</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 6876

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 15958

Certificate of Death

Reg. No.

| | | | | | | | | |
|---|--|---|---|--|---|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
LEON WIGGINS | | | | 2. Date of Death
Month MAY Day 12 Year 1996 | | 3. Time of Death
730 AM | |
| | 4a. Facility Name (If not institution, give street and number)
GOOD SAMARITAN HOSPITAL | | | | 4b. City, Town, or Location of Death
BALTIMORE | | 4c. County of Death
BALTIMORE | |
| Funeral
Director | 5. Social Security Number
216-09-2012 | | 6. Sex
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday)
86 Yrs. | | 8. Date of Birth (Month, Day, Year)
12/26/1909 | |
| | 9. Birthplace (State or Foreign Country)
BALTIMORE, MD. | | | | | | | |
| Usual Residence of Decedent | | | | | | | | |
| 10a. State
MARYLAND | | 10b. County
CITY | | 10c. City, Town or Location
BALTIMORE | | | 10d. Inside City Limits
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| 10e. Street and Number
3827 FERNDAL AVE. | | | | 10f. Zip Code
21207 | | 10g. Citizen of What Country?
USA | | |
| 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever In U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc.
Specify: ARFO AMERICAN | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (1-4 or 5+) 0 | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
UNKNOWN | | | 16b. Kind of Business/Industry
UNKNOWN | |
| 17. Father's Name (First, Middle, Last)
WILLIAMS BROOKS | | | | 18. Mother's Name (First, Middle, Maiden Summa)
LOUISA BARNES | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
FAYE EVANS | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
3827 FERNDAL AVE, BALTIMORE, MARYLAND 21207 | | | | |
| 20a. Method of Disposition
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
DULANEY VALLEY MEM. GARDEN | | | 20c. Location - City or Town, State
5/17/96 TIMONIUM, MARYLAND | | |
| 21. Signature of Funeral Service Licensee
 | | | | 22. Name and Address of Facility
ESTEP BROTHERS FUNERAL HOME, P.A.
1300 EUTAW PLACE, BALTIMORE, MARYLAND 21217 | | | | |
| 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

<div style="display: flex; justify-content: space-between;"> <div style="width: 60%;"> <p>Immediate Cause (Final disease or condition resulting in death)</p> <p>a. RESPIRATORY FAILURE
Due to (or as a consequence of):</p> <p>b. CHRONIC OBSTRUCTIVE PULMONARY DISEASE
Due to (or as a consequence of):</p> <p>c. _____
Due to (or as a consequence of):</p> <p>d. _____
Due to (or as a consequence of):</p> </div> <div style="width: 35%;"> <p>Approximate Interval Between Onset and Death</p> <p>2 Days</p> <p>10 YRS</p> </div> </div> | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
HYPERTENSION
CONGESTIVE HEART FAILURE | | | | | | 23b. Did tobacco use contribute to the cause of death?
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | |
| | | | | | | 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | |
| | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | |
| 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | 26. Place of Death (Check only one)
Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. Manner of Death
1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| | | | 28d. Describe how injury occurred | | | 28e. Location (Street and Number or Rural Route Number, City or Town, State) | | |
| 29a. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | |
| 29b. Signature and title of certifier
MD | | | | 29c. License number
047993 | | 29d. Date signed (Month, Day, Year)
MAY 12, 1996 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
GABRIEL NAZARENO 5601 LUCH RAVEN BLVD., BALTIMORE MD 21239 | | | | | | | | |
| 31. Date filed (Month, Day, Year)
MAY 30 1996 | | | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

State Registrar

96 15959

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|---|--|---|--|--|---|
| 1. DECEDENT'S NAME (First, Middle, Last)
<u>Victor Williams</u> | | | | 2. DATE OF DEATH
MONTH <u>May</u> DAY <u>20</u> YEAR <u>96</u> | | 3. TIME OF DEATH
<u>11:00 A</u> M | |
| 4. SOCIAL SECURITY NUMBER
<u>216 68 5412</u> | | 5. SEX
<u>1</u> <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
<u>39</u> YRS. | | 7. DATE OF BIRTH
(Month, Day, Year)
<u>10/30/56</u> | |
| 8. BIRTHPLACE (State or Foreign Country)
<u>MD.</u> | | | | 9a. FACILITY NAME (If not institution, give street and number)
<u>UNIVERSITY HOSPITAL</u> | | 9b. CITY, TOWN OR LOCATION OF DEATH
<u>BALTIMORE</u> | |
| 9c. COUNTY OF DEATH
<u>BALTO. CITY</u> | | | | 10a. STATE
<u>MD.</u> | | 10b. COUNTY
<u>BALTO. CITY</u> | |
| 10c. CITY, TOWN OR LOCATION
<u>BALTIMORE</u> | | | | 10d. INSIDE CITY LIMITS?
<u>1</u> <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | 10e. STREET AND NUMBER
<u>644 COKEBURY AVE.</u> | |
| 10f. ZIP CODE
<u>21218</u> | | | | 10g. CITIZEN OF WHAT COUNTRY?
<u>USA</u> | | 11. MARITAL STATUS
<u>2</u> <input checked="" type="checkbox"/> Married
<u>3</u> <input type="checkbox"/> Widowed <u>4</u> <input type="checkbox"/> Divorced | |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <u>1</u> <input type="checkbox"/> YES <u>2</u> <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
<u>1</u> <input type="checkbox"/> YES <u>2</u> <input checked="" type="checkbox"/> NO Specify: | | | |
| 14. RACE — American Indian, Black, White, etc.
Specify: <u>BLACK</u> | | | | 15. DECEDENT'S EDUCATION
(Specify only highest grade completed)
Elementary/Secondary (0-12) <u>12</u> College (1-4 or 5+) <u>0</u> | | | |
| 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.)
<u>MAINTENANCE MAN</u> | | | | 16b. KIND OF BUSINESS/INDUSTRY
<u>HOSPITAL</u> | | | |
| 17. FATHER'S NAME (First, Middle, Last)
<u>LEONARD MCDAD</u> | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
<u>IRENE WILLIAMS</u> | | | |
| 19a. INFORMANT'S NAME (Type/Print)
<u>LINDA WILLIAMS SISTER</u> | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
<u>644 COKEBURY AVE, BALTO. MD. 21218</u> | | | |
| 20a. METHOD OF DISPOSITION
<u>1</u> <input checked="" type="checkbox"/> Burial <u>2</u> <input type="checkbox"/> Cremation <u>3</u> <input type="checkbox"/> Removal from State
<u>4</u> <input type="checkbox"/> Donation <u>5</u> <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
<u>MT. ZION CEM. 5/24/96</u> | | 20c. LOCATION — City or Town, State
<u>LANSDOWNE, MD.</u> | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
<u>Estep</u> | | | | 22. NAME AND ADDRESS OF FACILITY
<u>ESTEP BROTHERS FUNERAL HOME P.A.
1300 FUTAW PL. BALTO. MD. 21217</u> | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
IMMEDIATE CAUSE (Final disease or condition resulting in death) → <u>Pneumonia</u>
DUE TO (OR AS A CONSEQUENCE OF):
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
<u>AIDS / Bacteremia / Fungemia</u> | | | | | | | Approximate Interval Between Onset and Death |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
<u>AIDS / Bacteremia / Fungemia</u> | | | | | | | 24a. WAS AN AUTOPSY PERFORMED?
<u>1</u> <input type="checkbox"/> YES <u>2</u> <input checked="" type="checkbox"/> NO |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/> | | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
<u>1</u> <input type="checkbox"/> YES <u>2</u> <input type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
<u>1</u> <input type="checkbox"/> YES <u>2</u> <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: <u>1</u> <input checked="" type="checkbox"/> Inpatient <u>2</u> <input type="checkbox"/> ER/Outpatient <u>3</u> <input type="checkbox"/> DOA
OTHER: <u>4</u> <input type="checkbox"/> Nursing Home <u>5</u> <input type="checkbox"/> Residence <u>6</u> <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH
<u>1</u> <input checked="" type="checkbox"/> Natural <u>5</u> <input type="checkbox"/> Pending Investigation
<u>2</u> <input type="checkbox"/> Accident <u>3</u> <input type="checkbox"/> Suicide <u>4</u> <input type="checkbox"/> Homicide <u>6</u> <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY
(Month, Day, Year) | | 28b. TIME OF INJURY
<u>M</u> | | 28c. INJURY AT WORK?
<u>1</u> <input type="checkbox"/> YES <u>2</u> <input type="checkbox"/> NO | |
| 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28d. DESCRIBE HOW INJURY OCCURRED | | | | | |
| 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | 29a. CERTIFIER
(Check only one)
<u>1</u> <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<u>2</u> <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
<u>Michael Gallashev MD</u> | | | | 29c. LICENSE NUMBER
<u>P 07745</u> | | 29d. DATE SIGNED (Month, Day, Year)
<u>5/20/96</u> | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
<u>Michael Gallashev 225 Green St Baltimore, MD 21201</u> | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
<u>MAY 30 1996</u> | | | | 32. REGISTRAR'S SIGNATURE
<u>John Davidson-Randall</u> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Certificate of Death

Reg. No.

| | | | | | | | | | | | | | | |
|---|--|--|---|---|--|--|---|--|--|---|--|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
HAROLD WILLIAM | | 2. Date of Death
Month Day Year
MAY 13, 1996 | | 3. Time of Death
19:07 P | | | | | | | | | |
| | 4a. Facility Name (If not institution, give street end number)
MERCY MEDICAL CENTER | | | 4b. City, Town, or Location of Death
BALTIMORE | | 4c. County of Death
Baltimore; CITY | | | | | | | | |
| | 5. Social Security Number
216-84-8824 | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) Yrs.
33 | | 8. Date of Birth (Month, Day, Year)
4/4/63 | | 9. Birthplace (State or Foreign Country)
MD. | | | | | |
| | Usuel Residence of Decedent | | | 10e. State
MD. | | | 10b. County
BALTO, | | | 10c. City, Town or Location
BALTIMORE | | | 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| | 10e. Street end Number
7216 OAKHEAVEN CIRCLE (APT 201) | | | 10f. Zip Code
21244 | | | 10g. Citizen of What Country?
usa | | | | | | | |
| | 11. Marital Status
<input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc.
Specify: BLACK | | | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12
College (1-4 or 5+) 0 | | | 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired)
unknown | | | 16b. Kind of Business/Industry
unknown | | | | | | | | |
| 17. Father's Name (First, Middle, Last)
HENRY WILLIAMS | | | 18. Mother's Name (First, Middle, Maiden Surname)
SHIRLEY WILLIAMS | | | | | | | | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
SHIRLEY WILLIAMS MOTHER | | | 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code)
7216 OAKHEAVEN CIRCLE BALTO. MD. 21244 (201) | | | | | | | | | | | |
| 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Mt. Calvary Cemetery | | | Date
5-21-96 | | 20c. Location - City or Town, State
Brooklyn MD | | | | | | |
| 21. Signature of Funeral Service Licensee
[Signature] | | | 22. Name and Address of Facility
ESTEP BROTHERS FUNERAL HOME P.A.
1300 EUTAW PL. BALTO. MD. 21217 | | | | | | | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

<div style="display: flex;"><div style="flex: 1;">Immediate Cause (Final disease or condition resulting in death)

Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last</div><div style="flex: 1; border-left: 1px solid black; padding-left: 10px;"><div>a. PULMONARY THROMBOSIS
Due to (or es a consequence of):</div><div>b. Due to (or es a consequence of):</div><div>c. Due to (or es a consequence of):</div><div>d. </div></div></div> | | | | | | | | | | | | | Approximate Interval Between Onset and Death | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
DILATED CARDIOMYOPATHY | | | | | | | | | | | | | | |
| 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | | | | | | | | | | |
| 24a. Was an autopsy performed?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | |
| 25. Was case referred to medical examiner?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation
<input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined
<input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | | | | | |
| | | | 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) | | | | | 28f. Location (Street end Number or Rural Route Number, City or Town, State) | | | | | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Certifying Physician: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | | | | | | | |
| 29b. Signature and title of certifier
[Signature] | | | 29c. License number
OCME | | | | | 29d. Date signed (Month, Day, Year)
MAY 14, 1996 | | | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
J. A. L. Lock, MD, 141 Penn Street, Baltimore, Maryland 21201 | | | | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
MAY 30 1996 | | | | | | | | | | | | | | |

96 15961

item#4, filmg 736, 6/14/96,cyw, per fh

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
<u>Elizabeth Sparks Welsh</u> | | | | 2. DATE OF DEATH
MONTH <u>5</u> DAY <u>25</u> YEAR <u>96</u> | | 3. TIME OF DEATH
<u>4:00 P M</u> | |
| 4. SOCIAL SECURITY NUMBER
<u>214-38-2965</u>
214-18-2215 | | 5. SEX
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
<u>90</u> YRS. | | 7. DATE OF BIRTH (Month, Day, Year)
<u>Aug 5, 1905</u> | |
| 8. BIRTHPLACE (State or Foreign Country)
<u>Md</u> | | | | 9a. FACILITY NAME (If not institution, give street and number)
<u>141 Hollow Brook Rd</u> | | 9b. CITY, TOWN OR LOCATION OF DEATH
<u>Timonium</u> | |
| 9c. COUNTY OF DEATH
<u>Baltimore</u> | | | | 10a. STATE
<u>Md</u> | | 10b. COUNTY
<u>Baltimore</u> | |
| 10c. CITY, TOWN OR LOCATION
<u>Timonium</u> | | | | 10d. INSIDE CITY LIMITS?
1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 10e. STREET AND NUMBER
<u>141 Hollow Brook Road</u> | |
| 10f. ZIP CODE
<u>21093</u> | | | | 10g. CITIZEN OF WHAT COUNTRY?
<u>USA</u> | | 11. MARITAL STATUS
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify:
<u>white</u> | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12) <u>4+</u> College (1-4 or 5+) <u>4+</u> | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
<u>School Teacher</u> | | 16b. KIND OF BUSINESS/INDUSTRY
<u>Education</u> | |
| 17. FATHER'S NAME (First, Middle, Last)
<u>William Edward Sparks</u> | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
<u>Anna Elizabeth Todd</u> | | | |
| 19a. INFORMANT'S NAME (Type/Print)
<u>Terry Clark/Friend</u> | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
<u>141 Hollow Brook Rd, Timonium, Md 21093</u> | | | |
| 20a. METHOD OF DISPOSITION
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
<u>Oaklawn Cemetery</u> <u>5/29</u> | | 20c. LOCATION — City or Town, State
<u>Baltimore, Md</u> | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
<u>E. A. Gyll</u> | | | | 22. NAME AND ADDRESS OF FACILITY
<u>Bradley Ashton Funeral Home</u>
<u>2134 Willow Spring Road Balto, md 21222</u> | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>Alzheimer's Dementia</u>
DUE TO (OR AS A CONSEQUENCE OF):
Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. _____ DUE TO (OR AS A CONSEQUENCE OF):
c. _____ DUE TO (OR AS A CONSEQUENCE OF):
d. _____ | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA
OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation
2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 6 <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
<u>M</u> | | 28c. INJURY AT WORK?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | 29a. CERTIFIER (Check only one)
1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
<u>Bruce C. Higginbotham</u> | | | | 29c. LICENSE NUMBER
<u>D0050132</u> | | 29d. DATE SIGNED (Month, Day, Year)
<u>5/25/96</u> | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
<u>Bruce C. Higginbotham 9000 Franklin Square Dr. Baltimore MD 21237</u> | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
<u>MAY 3 01996</u> | | | | 32. REGISTRAR'S SIGNATURE
<u>J. Davidson-Randall</u> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 15962

Certificate of Death

Reg. No.

| | | | | | | | | |
|--|---|---|--|---|---|---|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
CHARLES YOUNG | | | | 2. Date of Death
Month MAY Day 23 Year 1996 | | 3. Time of Death
14:25 PM | |
| | 4a. Facility Name (If not institution, give street and number)
THE JOHNS HOPKINS HOSPITAL | | | | 4b. City, Town, or Location of Death
BALTIMORE CITY | | 4c. County of Death | |
| Funeral
Director | 5. Social Security Number
216-52-7538 | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday)
48 Yrs. | | 8. Date of Birth (Month, Day, Year)
SEPT. 20 1947 | |
| | Usual Residence of Decedent | | 9. Birthplace (State or Foreign Country)
MARYLAND | | 10a. State
MARYLAND | | 10b. County
ANNE ARUNDEL | |
| To Be Completed by Funeral Director | 10c. City, Town or Location
PASADENA | | 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 10e. Street and Number
7641 PLEASANT DRIVE | | 10f. Zip Code
21122 | |
| | 10g. Citizen of What Country?
U.S.A. | | 11. Marital Status
<input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | |
| | 14. Race - American Indian, Black, White, etc.
Specify: WHITE | | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 9 College (1-4 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
PRINTER | | 16b. Kind of Business/Industry
ENVELOPE CO. | |
| | 17. Father's Name (First, Middle, Last)
CHARLES H. YOUNG JR. | | 18. Mother's Name (First, Middle, Maiden Surname)
SHIRLEY M. NESS | | 19a. Informant's Name/Relationship (Type, Print)
SHIRLEY M. SNYDER / Mother | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
7641 Pleasant Drive Pasadena, Maryland 21122 | |
| | 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
HOLLY HILL CEMETERY | | 20c. Date
5/28/96 | | 20d. Location - City or Town, State
CHASE, MARYLAND | |
| | 21. Signature of Funeral Service Licensee
Hillary Stallings Jr. | | 22. Name and Address of Facility
STALLINGS FUNERAL HOME P.A.
3111 MOUNTAIN ROAD PASADENA, MARYLAND 21122 | | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Acute renal failure
Due to (or as a consequence of):

b. Cytomegalovirus meningoencephalitis
Due to (or as a consequence of):

c. Cytomegalovirus retinitis
Due to (or as a consequence of):

d. Acquired Immunodeficiency Syndrome | | Approximate Interval Between Onset and Death

5 days

2 months

2 months

2 years | |
| | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | |
| | 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of injury (Month, Day, Year) | |
| | 28b. Time of injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | | 28e. Place of injury - At home, term, street, factory, office building, etc. (Specify) | |
| | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier
Sherita A Hill, MD Housestaff | | 29c. License number
M6279 | |
| 29d. Date signed (Month, Day, Year)
May 23, 1996 | | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Dr. Sherita A. Hill Tower 110 Doctor's Lounge Johns Hopkins Hospital Baltimore, MD 21287 | | 31. Date filed (Month, Day, Year)
MAY 3 01996 | | 32. Registrar's Signature
Lelia Perkins-Randall | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

96 15963

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
MARGARETA ALLEN | | | | 2. DATE OF DEATH
MONTH DAY YEAR
May 6, 1996 | | 3. TIME OF DEATH
3:50 A M | |
| 4. SOCIAL SECURITY NUMBER
578-56-5670 | | 5. SEX
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
64 YRS. | | 7. DATE OF BIRTH (Month, Day, Year)
Dec. 26, 1931 | |
| 8. BIRTHPLACE (State or Foreign Country)
Germany | | | | 9. FACILITY NAME (If not institution, give street and number)
Meridian Nursing Center | | | |
| 10. CITY, TOWN OR LOCATION OF DEATH
Frederick | | | | 11. COUNTY OF DEATH
Frederick | | | |
| 12. RESIDENCE OF DECEDENT | | | | 13. INSIDE CITY LIMITS?
1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | |
| 14. STATE
Maryland | | 15. COUNTY
Frederick | | 16. CITY, TOWN OR LOCATION
Frederick | | 17. ZIP CODE
21702 | |
| 18. STREET AND NUMBER
P 101 Waverly Drive | | | | 19. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 20. MARITAL STATUS
1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | |
| 21. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | | | 22. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | | |
| 23. RACE — American Indian, Black, White, etc.
Specify: White | | | | 24. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (1-4 or 5+) College | | | |
| 25. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
Sales Clerk | | | | 26. KIND OF BUSINESS/INDUSTRY
None | | | |
| 27. FATHER'S NAME (First, Middle, Last)
Johanns Distler | | | | 28. MOTHER'S NAME (First, Middle, Maiden Surname)
Maria Gebherd | | | |
| 29. INFORMANT'S NAME (Type/Print)
Charles W. Allen | | | | 30. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
P 101 Waverly Drive, Frederick, Maryland 21702 | | | |
| 31. METHOD OF DISPOSITION
1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 32. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
Smithsburg Crematory 5/7 | | 33. LOCATION — City or Town, State
Smithsburg, Maryland | |
| 34. SIGNATURE OF FUNERAL SERVICE LICENSE
<i>Robert E. Dailey</i> | | | | 35. NAME AND ADDRESS OF FACILITY
ROBERT E. DAILEY & SON FUNERAL HOMES, P.A.
1201 NORTH MARKET ST. FREDERICK, MD 21701 | | | |
| 36. PART I. Enter the diseases, or complications, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
IMMEDIATE CAUSE (Final disease or condition resulting in death) →
Ventricular Fibrillation
Coronary Artery Disease
Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
Diabetes Mellitus
COPD | | | | | | | |
| 37. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Diabetes Mellitus
COPD | | | | | | | |
| 38. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | |
| 39. WAS CASE REFERRED TO MEDICAL EXAMINER?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | 40. PLACE OF DEATH (Check only one)
HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA
OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | |
| 41. MANNER OF DEATH
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide
5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | | | 42. DATE OF INJURY (Month, Day, Year)
May 6, 1996 | | | |
| 43. TIME OF INJURY
M | | | | 44. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | |
| 45. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
At home | | | | 46. DESCRIBE HOW INJURY OCCURRED | | | |
| 47. CERTIFIER (Check only one)
1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 48. SIGNATURE AND TITLE OF CERTIFIER
<i>Allen J. Gilson</i> | | | | 49. LICENSE NUMBER
D26516 | | 50. DATE SIGNED (Month, Day, Year)
MAY 7 1996 | |
| 51. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
Allen J. Gilson, MD 1475 Taney Avenue, Frederick, Maryland 21701 | | | | | | | |
| 52. DATE FILED (Month, Day, Year)
MAY 07 1996 | | | | 53. REGISTRAR'S SIGNATURE
<i>Davidson Radcliff</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 6876

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 15964

| | | | | | | | | | | |
|---|--|---|---|--|--|---|--|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
ALBERTA M. ALLEN | | | | 2. Date of Death
Month MAY Day 16 Year 1996 | | 3. Time of Death
2:35 PM | | | |
| | 4a. Facility Name (If not institution, give street and number)
SOUTHERN MARYLAND HOSPITAL | | | | 4b. City, Town, or Location of Death
CLINTON | | 4c. County of Death
PRINCE GEORGES | | | |
| Funeral
Director | 5. Social Security Number
577-16-2603 | | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)
94 Yrs. | If Under 1 Year
Months | If Under 24 Hrs.
Hours Min. | 8. Date of Birth (Month, Day, Year)
March 11, 1902 | 9. Birthplace (State or Foreign Country)
Pennsylvania | | |
| | Usual Residence of Decedent | | | | | | | | | |
| To Be Completed by Funeral Director | 10a. State
Maryland | | 10b. County
Prince George's | | 10c. City, Town or Location
Clinton | | 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | |
| | 10e. Street and Number
Pineview Nursing Home
9106 Pinview Lane | | | | 10f. Zip Code
20735 | | 10g. Citizen of What Country?
U.S.A. | | | |
| | 11. Marital Status
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: White | | | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 10th | | College (1-4or 5+) N/A | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Homemaker | | 16b. Kind of Business/Industry
Home | | | |
| | 17. Father's Name (First, Middle, Last)
Harry O. Fisher | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Bertha Gregor | | | | | |
| | 19a. Informant's Name/Relationship (Type, Print)
Kenneth Allen Sr. | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
6104 Buckler Road Clinton Maryland 20735 | | | | | |
| | 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Cedar Hill Cemetery | | Date
May 20, 1996 | | 20c. Location - City or Town, State
Suitland Maryland | | | |
| | 21. Signature of Funeral Service Licensee
[Signature] | | | | 22. Name and Address of Facility
Lee Funeral Home, Inc.
6633 Old Alexandria Ferry Rd Clinton, Md 20735 | | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. URINARY TRACT INFECTION
Due to (or as a consequence of):
b. WITH SEPSIS
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
{ | | | | | | | | Approximate Interval Between Onset and Death
10 DAYS | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE
CHRONIC RENAL FAILURE | | | | | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | |
| 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28. Place of Death (Check only one)
Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury et Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how Injury occurred | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier
[Signature] | | | | | | 29c. License number
D-18545 | | |
| 29d. Date signed (Month, Day, Year)
MAY 16, 1996 | | 29e. Name and address of person who completed cause of death (Item 23e) (Type, Print)
PHILIP WISOTSKY M.D. 6188 Oxon Hill Rd, #601, Oxon Hill, Md | | | | | | | | |
| 31. Date filed (Month, Day, Year)
MAY 21 1996 | | 32. Registrar's Signature
[Signature] | | | | | | | | |

The following is a list of the names of the persons who have been appointed to the various positions in the Department of the Interior, under the act of March 3, 1879, entitled "An Act to provide for the better management of the public lands, and for other purposes."

| Position | Name |
|---|----------------|
| Secretary | John W. Foster |
| Assistant Secretary | John W. Foster |
| Chief of Bureau | John W. Foster |
| Assistant Chief of Bureau | John W. Foster |
| Commissioner of the General Land Office | John W. Foster |
| Assistant Commissioner of the General Land Office | John W. Foster |
| Surveyor General | John W. Foster |
| Assistant Surveyor General | John W. Foster |
| Inspector of Mines | John W. Foster |
| Assistant Inspector of Mines | John W. Foster |
| Chief of the Bureau of Reclamation | John W. Foster |
| Assistant Chief of the Bureau of Reclamation | John W. Foster |
| Chief of the Bureau of Indian Affairs | John W. Foster |
| Assistant Chief of the Bureau of Indian Affairs | John W. Foster |
| Chief of the Bureau of Fish and Game | John W. Foster |
| Assistant Chief of the Bureau of Fish and Game | John W. Foster |
| Chief of the Bureau of Forestry | John W. Foster |
| Assistant Chief of the Bureau of Forestry | John W. Foster |
| Chief of the Bureau of Geology | John W. Foster |
| Assistant Chief of the Bureau of Geology | John W. Foster |
| Chief of the Bureau of Land Management | John W. Foster |
| Assistant Chief of the Bureau of Land Management | John W. Foster |
| Chief of the Bureau of Natural History | John W. Foster |
| Assistant Chief of the Bureau of Natural History | John W. Foster |
| Chief of the Bureau of Palaeontology | John W. Foster |
| Assistant Chief of the Bureau of Palaeontology | John W. Foster |
| Chief of the Bureau of Zoology | John W. Foster |
| Assistant Chief of the Bureau of Zoology | John W. Foster |

96 15965

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | | |
|--|--|--|--|---|--|--|---|---|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
<u>Morris Jacob Akman</u> | | | | | | 2. DATE OF DEATH
MONTH DAY YEAR
<u>May 12 1996</u> | | 3. TIME OF DEATH
<u>1:55 A</u> M | | |
| 4. SOCIAL SECURITY NUMBER
<u>215-10-4929</u> | | 5. SEX
1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
<u>83</u> YRS. | | 7. DATE OF BIRTH
(Month, Day, Year)
<u>Jan. 3, 1913</u> | | 8. BIRTHPLACE (State or Foreign Country)
<u>Baltimore, MD</u> | | |
| 9a. FACILITY NAME (If not institution, give street and number)
<u>Holy Cross Hospital</u> | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
<u>Silver Spring</u> | | | 9c. COUNTY OF DEATH
<u>Montgomery</u> | | | |
| 10a. STATE
<u>Maryland</u> | | 10b. COUNTY
<u>Montgomery</u> | | 10c. CITY, TOWN OR LOCATION
<u>Silver Spring</u> | | | 10d. INSIDE CITY LIMITS?
1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | |
| 10e. STREET AND NUMBER
<u>2445 Lyttonsville Road, Apt. 900</u> | | | | 10f. ZIP CODE
<u>20910</u> | | | 10g. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> | | | |
| 11. MARITAL STATUS
1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | | 14. RACE — American Indian, Black, White, etc.
Specify:
<u>White</u> | | | |
| 15. DECEDENT'S EDUCATION
(Specify only highest grade completed)
Elementary/Secondary (0-12) <u>12 Years</u> College (1-4 or 5+) <u>College</u> | | | | 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.)
<u>Buyer</u> | | | 16b. KIND OF BUSINESS/INDUSTRY
<u>Kanns Department Store</u> | | | |
| 17. FATHER'S NAME (First, Middle, Last)
<u>Charles Akman</u> | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
<u>Sonia Eisenberg</u> | | | | | | |
| 19a. INFORMANT'S NAME (Type/Print)
<u>Rose S. Akman, Wife</u> | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
<u>2445 Lyttonsville Road, Apt. 900
Silver Spring, Maryland 20910</u> | | | | | | |
| 20a. METHOD OF DISPOSITION
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
<u>Mount Lebanon Cemetery 5/14/1996</u> | | | 20c. LOCATION — City or Town, State
<u>Adelphi, Maryland</u> | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
<u>Donald C. Stottmeyer</u> | | | | 22. NAME AND ADDRESS OF FACILITY
<u>STEIN HEBREW MEMORIAL FUNERAL HOME, INC.
232 CARROLL STREET, N.W.
WASHINGTON, D.C. 20012-2095</u> | | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
IMMEDIATE CAUSE (Final disease or condition resulting in death) →
<u>Acute Myocardial Infarction</u>
DUE TO (OR AS A CONSEQUENCE OF):
a. <u>Coronary Artery Disease</u>
DUE TO (OR AS A CONSEQUENCE OF):
b. <u>Ischemic Cardiomyopathy, Cerebrovascular Accident,</u>
c. <u>Diabetes Melitis</u>
DUE TO (OR AS A CONSEQUENCE OF):
d. <u>DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/></u> | | | | | | | | Approximate Interval Between Onset and Death
<u>Immediate</u>
<u>20 Years</u> | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
<u>Ischemic Cardiomyopathy, Cerebrovascular Accident,</u>
<u>Diabetes Melitis</u>
<u>DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/></u> | | | | | | | | 24a. WAS AN AUTOPSY PERFORMED?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 28. PLACE OF DEATH (Check only one)
HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA
OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | | |
| 27. MANNER OF DEATH
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation
2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined
3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY
(Month, Day, Year) | | 28b. TIME OF INJURY
<u>M</u> | | 28c. INJURY AT WORK?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | | |
| 29a. CERTIFIER (Check only one)
1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | 29b. SIGNATURE AND TITLE OF CERTIFIER
<u>John Yackee MD</u> | | | 29c. LICENSE NUMBER
<u>35261</u> | | 29d. DATE SIGNED (Month, Day, Year)
<u>May 12, 1996</u> | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
<u>John Yackee 3801 International Drive, #210, Silver Spring, Maryland 20906</u> | | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
<u>MAY 16 1996</u> | | | | 32. REGISTRAR'S SIGNATURE
<u>John Davidson Randall</u> | | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 96 15966

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Jeanette Cushwa Bester

2. Date of Death

Month Day Year
May 19, 1996

3. Time of Death

11:45 P. M.

Funeral
Director

4a. Facility Name (If not institution, give street and number)

939 Forest Drive

4b. City, Town, or Location of Death

Hagerstown

4c. County of Death

Washington

5. Social Security Number

218-24-8961

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

92

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Feb. 17, 1904

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Washington

10c. City, Town or Location

Hagerstown

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

939 Forest Drive

10f. Zip Code

21742

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

homemaker

16b. Kind of Business/Industry

home

17. Father's Name (First, Middle, Last)

Victor Monroe Cushwa

18. Mother's Name (First, Middle, Maiden Surname)

Susan Fechtig

19a. Informant's Name/Relationship (Type, Print)

W. Riley Daniels III

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2415 Eva Court Campbell Ca. 95008

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Rose Hill Cemetery

Date

5/23/96

20c. Location - City or Town, State

Hagerstown, Maryland

21. Signature of Funeral Service Licensee

Gerald N. Minnich

22. Name and Address of Facility

Gerald N. Minnich
Funeral Home

305 N. Potomac Street

Hagerstown, Maryland

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. *ATROSCHEMOTIC Heart Disease*

Due to (or as a consequence of):

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

yes

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

None

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☒ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of injury (Month, Day Year)

W/A

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

[Signature]

29c. License number

DO7885

29d. Date signed (Month, Day, Year)

5-20-96

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

*James H. Glorvick**354 Mill St**Hagerstown MD**21740*State
Registrar

31. Date filed (Month, Day, Year)

MAY 22 1996

32. Registrar's Signature

[Signature]

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 15967

Certificate of Death

Reg. No.

| | | | | | | | | | |
|--|--|--|---|--|--|---|--|---|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
George Edward BISER SR | | | | 2. Date of Death
May 15, 1996 | | 3. Time of Death
10:00 AM | | |
| | 4a. Facility Name (If not institution, give street and number)
9511-A Hansonville Road | | | | 4b. City, Town, or Location of Death
Frederick | | 4c. County of Death
Frederick | | |
| Funeral
Director | 5. Social Security Number
220-28-3399 | | 6. Sex
M <input checked="" type="checkbox"/> F <input type="checkbox"/> | 7. Age (In yrs. last birthday)
62 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth
(Month, Day, Year)
Sept. 22, 1933 | 9. Birthplace (State or Foreign Country)
Maryland | |
| | Usual Residence of Decedent | | | | | | | | |
| To Be Completed by Funeral Director | 10a. State
Maryland | | 10b. County
Frederick | | 10c. City, Town or Location
Frederick | | 10d. Inside City Limits
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | |
| | 10e. Street and Number
9511-B Hansonville Road | | | | 10f. Zip Code
21702 | | 10g. Citizen of What Country?
U.S.A. | | |
| | 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No
If Yes, Give Year or Dates: 1951-1959 | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: White | | |
| | 15. Decedent's Education
(Specify only highest grade completed)
Elementary/Secondary (0-12) College (1-4or 5+) | | 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)
Painter and Paper Hanger | | 16b. Kind of Business/Industry
Painting Contractor | | | | |
| | 17. Father's Name (First, Middle, Last)
Unknown | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Velma Grace BISER | | | | |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print)
Mrs. Mabel Ann Biser, Wife | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
9511-B Hansonville Road, Frederick, Maryland 21702 | | | | |
| | 20a. Method of Disposition
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Resthaven Memorial Gardens, May 17, 1996 | | 20c. Location - City or Town, State
Frederick, Maryland | | | | |
| | 21. Signature of Funeral Service Licensee
Richard E. Harg M00255 | | 22. Name and Address of Facility
Keeney and Basford P.A. Funeral Home
106 East Church St., Frederick, Maryland 21701 | | | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
s. Acute myocardial infarction
Due to (or as a consequence of):
b. Chronic Atherosclerosis
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d. | | | | | | | | |
| | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input checked="" type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide
5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how Injury occurred | |
| | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| 29a. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | |
| 29b. Signature and title of certifier
Dr. Jeffrey N. Cowen MD | | | | 29c. License number
D 30721 | | 29d. Date signed (Month, Day, Year)
May 15, 1996 | | | |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)
Dr. Jeffrey N. Cowen MD 310 West Ninth Street, Frederick, Maryland 21701 | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
MAY 16 1996 | | 32. Registrar's Signature
Davidson Randall | | | | | | | |

Baltimore, Maryland 21215-0020

permits. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

96 15968

1 FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
Marion T. Beall, Jr. | | | | 2. DATE OF DEATH
MONTH May DAY 14 YEAR 1996 | | 3. TIME OF DEATH
12:30 A M | |
| 4. SOCIAL SECURITY NUMBER
215-16-2862 | | 5. SEX
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
85 YRS. | | 7. DATE OF BIRTH (Month, Day, Year)
Jan. 30, 1911 | |
| 8. BIRTHPLACE (State or Foreign Country)
Maryland | | | | 9a. CITY, TOWN OR LOCATION OF DEATH
Rockville | | 9c. COUNTY OF DEATH
Montgomery | |
| 9b. FACILITY NAME (If not institution, give street and number)
Shady Grove Adventist Nursing Home | | | | | | | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE
Maryland | | 10b. COUNTY
Montgomery | | 10c. CITY, TOWN OR LOCATION
Washington Grove | | 10d. INSIDE CITY LIMITS?
<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER
119 Washington Grove Lane | | | | 10f. ZIP CODE
20880 | | 10g. CITIZEN OF WHAT COUNTRY?
United States | |
| 11. MARITAL STATUS
1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify: White | |
| 15. DECEDENT'S EDUCATION
(Specify only highest grade completed)
Elementary/Secondary (0-12) | | 15b. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.)
Carpenter | | 16b. KIND OF BUSINESS/INDUSTRY
Applied Physics Laboratory | | | |
| 17. FATHER'S NAME (First, Middle, Last)
Marion Templeman Beall, Sr. | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Carrie Gott | | | |
| 19a. INFORMANT'S NAME (Type/Print)
Lillian V. Beall | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
119 Washington Grove Lane, Washington Grove, Md. 20880 | | | |
| 20a. METHOD OF DISPOSITION
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
Forest Oak 5/17/96 | | 20c. LOCATION — City or Town, State
Gaithersburg, Md. | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
<i>Olin L. Molesworth</i> | | | | 22. NAME AND ADDRESS OF FACILITY
Olin L. Molesworth, P.A.
26401 Ridge Rd., Damascus, Md. 20872 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | | a. CHRONIC RENAL FAILURE
DUE TO (OR AS A CONSEQUENCE OF): | | | | | |
| Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | b. DIABETES MELLITUS - INSULIN RESISTANT
DUE TO (OR AS A CONSEQUENCE OF): | | | | | |
| | | c. HYPERTENSION
DUE TO (OR AS A CONSEQUENCE OF): | | | | | |
| | | d. LOWER URINARY OBSTRUCTION - B.P.H. | | | | | |
| | | Approximate interval Between Onset and Death
2 months
75 years
75 years
75 years | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Cystitis
Cerebrovascular insufficiency - Ischemia | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA
OTHER: <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation
2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined
3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Other (Specify)
4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 28c. INJURY AT WORK?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| | | 28d. DESCRIBE NOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. CERTIFIER (Check only one)
1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
<i>Richard N. Katon M.D.</i> | | | | 29c. LICENSE NUMBER
006258 | | 29d. DATE SIGNED (Month, Day, Year)
May 14, 1996 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
Richard N. Katon, M.D. 20528 Boland Farm Road, Germantown, Md. 20874 | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
MAY 15 1996 | | 32. REGISTRAR'S SIGNATURE
<i>John A. H. H. H.</i> | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

96 15969

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

| | | | | | | | | | | | | | | | | | | | |
|---|---|--|--|---|--|---|---------------------------------|--|----|--|--------|----|---|--------|----|--|--------|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
RANDOL BRIAN BAKER | | | | 2. DATE OF DEATH
MONTH DAY YEAR
May 12, 1996 | | 3. TIME OF DEATH
12:57 AM | | | | | | | | | | | | | |
| 4. SOCIAL SECURITY NUMBER
218-80-6167 | | 5. SEX
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
36 YRS. | | 7. DATE OF BIRTH (Month, Day, Year)
July 6, 1959 | | | | | | | | | | | | | |
| 8. BIRTHPLACE (State or Foreign Country)
Maryland | | | | 9a. FACILITY NAME (If not institution, give street and number)
209 Waverly Drive | | 9b. CITY, TOWN OR LOCATION OF DEATH
Frederick | | | | | | | | | | | | | |
| 9c. COUNTY OF DEATH
Frederick | | | | 10a. STATE
Maryland | | 10b. COUNTY
Frederick | | | | | | | | | | | | | |
| 10c. CITY, TOWN OR LOCATION
Frederick | | | | 10d. INSIDE CITY LIMITS?
<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | 10e. STREET AND NUMBER
209 Waverly Drive | | | | | | | | | | | | | |
| 10f. ZIP CODE
21702 | | | | 10g. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | | | | | | | | | | | | | |
| 11. MARITAL STATUS
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify: White | | | | | | | | | | | | | |
| 15. DECEDENT'S EDUCATION
(Specify only highest grade completed)
Elementary/Secondary (0-12) College (1-4 or 5+)
2 1/2 yrs. | | 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.)
Accountant | | 16b. KIND OF BUSINESS/INDUSTRY
None | | | | | | | | | | | | | | | |
| 17. FATHER'S NAME (First, Middle, Last)
Gerald R. Baker | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Geneva L. Barnard | | | | | | | | | | | | | | | |
| 19a. INFORMANT'S NAME (Type/Print)
Gerald R. Baker | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1730 Florence Road, Mt. Airy, MD 21771 | | | | | | | | | | | | | | | |
| 20a. METHOD OF DISPOSITION
1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
Smithsburg Crematory 5/13 | | 20c. LOCATION — City or Town, State
Smithsburg, Maryland | | | | | | | | | | | | | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
 | | | | 22. NAME AND ADDRESS OF FACILITY
ROBERT E. DAILEY & SON FUNERAL HOMES, P.A.
1201 NORTH MARKET ST., FREDERICK, MD 21701 | | | | | | | | | | | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
IMMEDIATE CAUSE (Final disease or condition resulting in death) → AIDS
Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
<table border="0"> <tr> <td>a.</td> <td>DUE TO (OR AS A CONSEQUENCE OF)</td> <td>Approximate Interval Between Onset and Death</td> </tr> <tr> <td>b.</td> <td>Wasting Syndrome
DUE TO (OR AS A CONSEQUENCE OF)</td> <td>8 yrs.</td> </tr> <tr> <td>c.</td> <td>cryptosporidiosis
DUE TO (OR AS A CONSEQUENCE OF)</td> <td>2 yrs.</td> </tr> <tr> <td>d.</td> <td></td> <td>6 mths</td> </tr> </table> | | | | | | a. | DUE TO (OR AS A CONSEQUENCE OF) | Approximate Interval Between Onset and Death | b. | Wasting Syndrome
DUE TO (OR AS A CONSEQUENCE OF) | 8 yrs. | c. | cryptosporidiosis
DUE TO (OR AS A CONSEQUENCE OF) | 2 yrs. | d. | | 6 mths | | |
| a. | DUE TO (OR AS A CONSEQUENCE OF) | Approximate Interval Between Onset and Death | | | | | | | | | | | | | | | | | |
| b. | Wasting Syndrome
DUE TO (OR AS A CONSEQUENCE OF) | 8 yrs. | | | | | | | | | | | | | | | | | |
| c. | cryptosporidiosis
DUE TO (OR AS A CONSEQUENCE OF) | 2 yrs. | | | | | | | | | | | | | | | | | |
| d. | | 6 mths | | | | | | | | | | | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Nausea + Vomiting
Malnutrition | | | | | | 24a. WAS AN AUTOPSY PERFORMED?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | | | | | | | | | | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | | | | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA
OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | | | | | | | | | | | |
| 27. MANNER OF DEATH
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide
5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M | | 28c. INJURY AT WORK?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | | | | | | | | | | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | | | | | | | | | | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | | | | | | | | | | | | |
| 29a. CERTIFIER (Check only one)
1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | | | | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
Abelani | | | | 29c. LICENSE NUMBER
D26137 | | 29d. DATE SIGNED (Month, Day, Year)
5/13/96 | | | | | | | | | | | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
Anusha Belani, MD 198 Thomas Johnson Drive, Frederick, MD 21701 | | | | | | | | | | | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
MAY 13 1996 | | | | 32. REGISTRAR'S SIGNATURE
 | | | | | | | | | | | | | | | |

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 15970

Certificate of Death

Reg. No.

| | | | | | | | | | |
|---|--|--|---|---|---|---|---|---|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Jean Deloris BAKER | | | | 2. Date of Death
Month May Day 10 Year 1996 | | 3. Time of Death
12:15 AM | | |
| | 4a. Facility Name (If not institution, give street and number)
Meridian Nursing Center | | | | 4b. City, Town, or Location of Death
Frederick | | 4c. County of Death
Frederick | | |
| Funeral
Director | 5. Social Security Number
220-30-7746 | | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday)
60 Yrs. | | 8. Date of Birth (Month, Day, Year)
Nov. 17, 1935 | | |
| | 9. Birthplace (State or Foreign Country)
Maryland | | 10. Usual Residence of Decedent
10a. State Maryland 10b. County Frederick 10c. City, Town or Location Frederick 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 11. Street and Number
613 Himes Avenue, Unit 101 | | 12. Zip Code
21703 | | |
| 13. Marital Status
<input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 14. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 15. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 16. Race - American Indian, Black, White, etc.
Specify: White | | 17. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 11 College (1-4or 5+) College | |
| 18. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Homemaker | | 19. Kind of Business/Industry
Own Home | | 20. Father's Name (First, Middle, Last)
William Thomas KABRICK, JR. | | 21. Mother's Name (First, Middle, Maiden Surname)
Emily Louise LENHART | | 22. Informant's Name/Relationship (Type, Print)
Ricky L. Baker, Son | |
| 23. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
613 Himes Ave., Unit 101, Frederick, Md. 21703 | | 24. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 25. Place of Disposition (Name of cemetery, crematory or other place)
Resthaven Memorial Gardens, May 13, 1996 | | 26. Location - City or Town, State
Frederick, Md. | | 27. Signature of Funeral Service Licensee
Richard E. Haff M00255 | |
| 28. Name and Address of Facility
Keeney and Basford P.A. Funeral Home
106 East Church St., Frederick, Md. 21701 | | 29. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
CORONARY ARTERY DISEASE
Due to (or as a consequence of):
DIABETIS MELLITUS
Due to (or as a consequence of):
PERIPHERAL VASCULAR DISEASE
Due to (or as a consequence of): | | 30. Approximate Interval Between Onset and Death
1993
1975
1991
6/12/91 | | 31. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Hypothyroidism 1990
Systemic Lupus Erythematosus 1991
PARANOID SCHIZOPHRENIA | | 32. Did tobacco use contribute to the cause of death?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | |
| 33. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 34. Piece of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | 35. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 36. Date of Injury (Month, Day, Year) | | 37. Time of Injury
M | |
| 38. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 39. Describe how Injury occurred | | 40. Location (Street and Number or Rural Route Number, City or Town, State) | | 41. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 42. Signature and title of certifier
Dr. James S. Grissom MD | |
| 43. License number
D 21944 | | 44. Date signed (Month, Day, Year)
May 10, 1996 | | 45. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Dr. James S. Grissom MD 300 West Ninth Street, Frederick, Maryland 21701 | | 46. Date filed (Month, Day, Year)
MAY 13 1996 | | 47. Registrar's Signature
John A. ... | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 15971

Certificate of Death

Reg. No.

| | | | | | | | | |
|---|---|--|--|---|--|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Catherine Louise BARE | | | | 2. Date of Death
Month May Day 5 Year 1996 | | 3. Time of Death
4:00 P.M. | |
| | 4a. Facility Name (If not institution, give street and number)
26 Winchester Street | | | | 4b. City, Town, or Location of Death
Frederick | | 4c. County of Death
Frederick | |
| Funeral
Director | 5. Social Security Number
215-20-9370 | | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)
89 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth (Month, Day, Year)
Feb. 8, 1907 | 9. Birthplace (State or Foreign Country)
Maryland |
| | Usual Residence of Decedent
10a. State Maryland 10b. County Frederick 10c. City, Town or Location Frederick 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | 10e. Street and Number
26 Winchester Street | | 10f. Zip Code
21701 | |
| 11. Marital Status
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: White |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 5 Collage (1-4 or 5+) Collage | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Cook - baker | | 16b. Kind of Business/Industry
Restaurant | | |
| 17. Father's Name (First, Middle, Last)
John William Speak | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Nellie Gertrude Simmers | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
Charles William Bare | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
202 West 12th Street, Frederick, Md. 21701 | | | | |
| 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Mt. Olivet Cemetery | | 20c. Location - City or Town, State
May 8, 1996 Frederick, Maryland | | |
| 21. Signature of Funeral Service Licensee
<i>Richard C.C. Basford</i> M00021 | | | | 22. Name and Address of Facility
Keeney and Basford Funeral Home
106 East church Street, Frederick, Md. 21701 | | | | |
| 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. Cardiac Arrhythmia
Due to (or as a consequence of):
b. Coronary Artery Disease
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | | Approximate Interval Between Onset and Death
few hours
few years |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Chronic Fibrillation | | | | | | | | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |
| 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |
| 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one)
Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |
| 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28d. Describe how injury occurred | | | | |
| 29a. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | 29b. Signature and title of certifier
<i>[Signature]</i> | | 29c. License number
D18063 | | 29d. Date signed (Month, Day, Year)
5/6/96 |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
A. Majeed, M.D., 801 Toll House Ave., Frederick, Maryland 21701 | | | | | | | | |
| 31. Date filed (Month, Day, Year)
MAY 07 1996 | | | | 32. Registrar's Signature
<i>[Signature]</i> | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

State
Registrar

96-2728-015

96-015

B.K.S

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 15972

Certificate of Death

Reg. No.

| | | | | | | | | |
|---|--|--|---|--|--|---|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
RONALD JUNIOR BOGGS | | | | 2. Date of Death
Month Day Year
MAY 19, 1996 | | 3. Time of Death
2022 PM | |
| | 4a. Facility Name (If not institution, give street and number)
515 WEST LEWIS SHORE ROAD | | | | 4b. City, Town, or Location of Death
ELKTON | | 4c. County of Death
CECIL | |
| Funeral
Director | 5. Social Security Number
212-02-9535 | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)
30 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth
(Month, Day, Year)
December 16 1965 | 9. Birthplace (State or Foreign Country)
Maryland | |
| | Usual Residence of Decedent | | | | | | | |
| To Be Completed by Funeral Director | 10a. State
Maryland | 10b. County
Cecil | 10c. City, Town or Location
Port Deposit | | | 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| | 10e. Street and Number
2059 Red Toad Road | | | 10f. Zip Code
21904 | | 10g. Citizen of What Country?
United States | | |
| | 11. Marital Status
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: White | |
| | 15. Decedent's Education
(Specify only highest grade completed)
Elementary/Secondary (0-12) 8 Collega (1-4or 5+) | | 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)
Carpenter | | | 16b. Kind of Business/Industry
New Home Construction | | |
| | 17. Father's Name (First, Middle, Last)
Ronald Gary Boggs | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Janice Fern Day | | | |
| | 19a. Informant's Name/Relationship (Type, Print)
James Blakeley | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
7 Spring House Court, Rising Sun, MD 21911 | | | |
| | 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Gilpin Manor Memorial Pk | | 20c. Location - City or Town, State
5/23/96 Elkton, Maryland | | | |
| | 21. Signature of Funeral Service Licensee
 | | | | 22. Name and Address of Facility
Crouch Funeral Home
127 South Main Street, North East, MD 21901 | | | |
| | 23e. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. Gun shot wound of head
Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | |
| 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | | | | | | |
| 24a. Was an autopsy performed?
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death?
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | | | | |
| 25. Was case referred to medical examiner?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) YARD | | | | | | |
| 27. Manner of Death
1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation
2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined
3 <input type="checkbox"/> Suicide 4 <input checked="" type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day, Year)
5-19-96 | | 28b. Time of Injury
2017 M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | |
| | | 28d. Describe how injury occurred
subject shot. | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
Yard | | 28f. Location (Street and Number or Rural Route Number, City or Town, State)
515 West Lewis Shore Rd | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Medical Examiner | | 29b. Signature and Title of certifier
 | | | | | | |
| | | 29c. License number
O.C.M.E | | 29d. Date signed (Month, Day, Year)
MAY 20, 1996 | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
David R Fowler 111 Penn Street, Baltimore, Maryland 21201 | | | | | | | | |
| 31. Date filed (Month, Day, Year)
MAY 21 1996 | | 32. Registrar's Signature
 | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

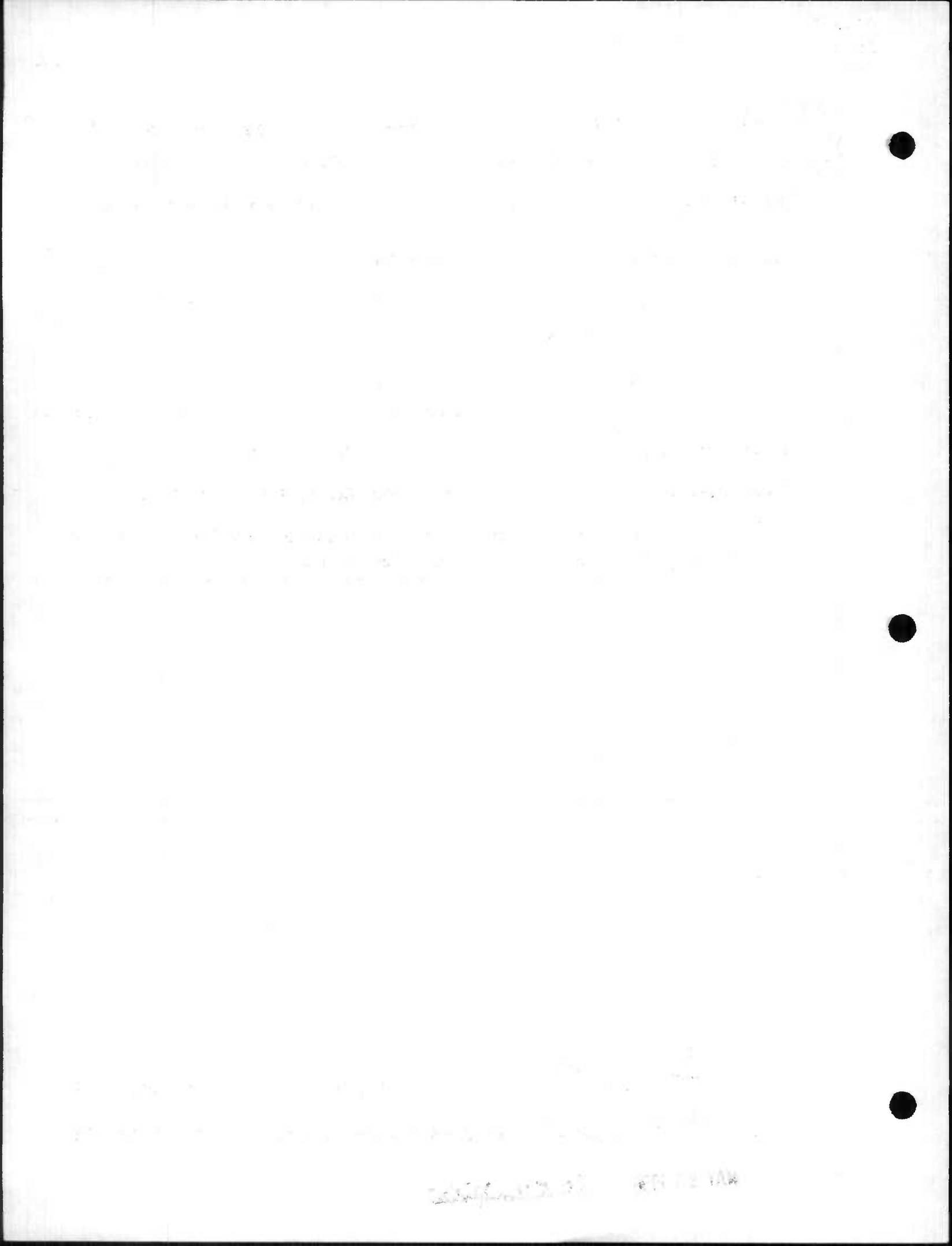
Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar




Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 15973

Certificate of Death

Reg. No.

| | | | | | | | | | |
|---|---|---|--|---|---|---|---|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Gerald Elwood Beamer Sr. | | | | 2. Date of Death
Month May Day 16 Year 1996 | | 3. Time of Death
3:30 A.M. | | |
| | 4a. Facility Name (If not institution, give street and number)
140 Hilltop Road | | | | 4b. City, Town, or Location of Death
Elkton | | 4c. County of Death
Cecil | | |
| Funeral
Director | 5. Social Security Number
213-20-0234 | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday)
81 Yrs. | | 8. Date of Birth (Month, Day, Year)
August 17, 1914 | | |
| | 9. Birthplace (State or Foreign Country)
Virginia | | 10a. State
Maryland | | 10b. County
Cecil | | 10c. City, Town or Location
Elkton | | |
| Usual Residence of Decedent | | 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 10e. Street and Number
140 Hilltop Road | | 10f. Zip Code
21921 | | 10g. Citizen of What Country?
United States | |
| 11. Marital Status
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: White | | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 11 College (1-4 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Lumberman | | 16b. Kind of Business/Industry
Lumber | | 17. Father's Name (First, Middle, Last)
William P. Beamer | | 18. Mother's Name (First, Middle, Maiden Surname)
Ivy M. Wortman | |
| 19a. Informant's Name/Relationship (Type, Print)
Larry M. Beamer/Son | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
140 Hilltop Road, Elkton, Maryland 21921 | | 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Gilpin Manor Memorial Park | | 20c. Location - City or Town, State
Elkton, Maryland | |
| 21. Signature of Funeral Service Licensee
 | | 22. Name and Address of Facility
Hicks Home for Funerals, P.A.
103 W. Stockton St., Elkton, Maryland 21921 | | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Carcinoma of the lung with metastasis
Due to (or as a consequence of):

b. Coronary artery disease
Due to (or as a consequence of):

c. Peripheral vascular disease
Due to (or as a consequence of):

d.
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last | | 23b. Did tobacco use contribute to the cause of death?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No | | 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | |
| 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input type="checkbox"/> No | | 28d. Describe how Injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier
 | | 29c. License number
D22189 | | 29d. Date signed (Month, Day, Year)
5/16/96 | | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Kenneth Corrin, M.D. Suite 211 West High Street, Elkton, Maryland 21921 | |
| 31. Date filed (Month, Day, Year)
MAY 16 1996 | | 32. Registrar's Signature
 | | | | | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

8

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 15974

Certificate of Death

Reg. No.

Amended item #5 per F.D. 5/22/96
Carroll Co. P.L.C.

| | | | | | |
|---|---|---|---|--|---|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
MARTHA G. BARNHART | | 2. Date of Death
Month MAY Day 17 Year 1996 | | 3. Time of Death
2 PM |
| | 4a. Facility Name (If not institution, give street and number)
NORTHWEST HOSPITAL | | 4b. City, Town, or Location of Death
RANDALLSTOWN | | 4c. County of Death
BALTIMORE |
| Funeral
Director | 5. Social Security Number
215-26-1461 | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)
65 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. |
| | 8. Date of Birth (Month, Day, Year)
OCT. 6. 1930 | | 9. Birthplace (State or Foreign Country)
PENNSYLVANIA | | |
| Usual Residence of Decedent | | | | | |
| 10a. State
MARYLAND | | 10b. County
CARROLL | | 10c. City, Town or Location
SYKESVILLE | |
| 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | | |
| 10e. Street and Number
7309 SECOND AVENUE | | 10f. Zip Code
21784 | | 10g. Citizen of What Country?
USA | |
| 11. Marital Status
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | |
| 14. Race - American Indian, Black, White, etc.
Specify: CAUCASIAN | | | | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 YEARS
College (1-4or 5+) HOUSEKEEPER | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | | 16b. Kind of Business/Industry
PRIVATE COLLEGE | |
| 17. Father's Name (First, Middle, Last)
EMMANUEL JEFFCOAT | | 18. Mother's Name (First, Middle, Maiden Surname)
ELIZA SILLIK | | | |
| 19a. Informant's Name/Relationship (Type, Print)
CHARLES E. BARNHART, JR. SON | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
23 FREDERICK STREET TANEYTOWN, MARYLAND 21787 | | | |
| 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
MEADOW BRANCH CEMETERY | | 20c. Location - City or Town, State
5/21/96 WESTMINSTER, MD. 21158 | |
| 21. Signature of Funeral Service Licensee
P. Kevin Judy | | 22. Name and Address of Facility
136 EAST BALTIMORE STREET SKILES FUNERAL HOME TANEYTOWN, MARYLAND 21787 | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
Immediate Cause (Final disease or condition resulting in death)
e. CONGESTIVE HEART FAILURE
Due to (or as a consequence of):
b. OLD MYOCARDIAL INFARCTION
Due to (or as a consequence of):
c. PERIPHERAL VASCULAR DISEASE
Due to (or as a consequence of):
d. PERIPHERAL VASCULAR DISEASE
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | |
| 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown | | | | | |
| 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | |
| 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | |
| 26. Place of Death (Check only one)
Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation
2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined
3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | |
| 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | | 28e. Piece of Injury - At home, farm, street, factory, office building, etc. (Specify) | |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | |
| 29b. Signature and title of certifier
Dr. [Signature] MD | | 29c. License number
D 27157 | | 29d. Date signed (Month, Day, Year)
MAY 17, 1996 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
RAYNOLD DEFEESTRE NORTH WEST HOSPITAL CENTER | | | | | |
| 31. Date filed (Month, Day, Year)
MAY 20 1996 | | 32. Registrar's Signature
[Signature] | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Certificate of Death

Reg. No.

| | | | | | | | | |
|--|--|--|--|---|---|--|---|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Jay A. Burke | | | 2. Date of Death
Month Day Year
May 17, 1996 | | 3. Time of Death
4:40 P | | |
| | 4a. Facility Name (If not institution, give street and number)
6507 Pin Oak Court (RESIDENCE) | | | 4b. City, Town, or Location of Death
Clinton | | 4c. County of Death
Prince George | | |
| Funeral
Director | 5. Social Security Number
0409
578-46-0490 | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday)
60 Yrs. | | 8. Date of Birth (Month, Day, Year)
July 4, 1935 | |
| | 9. Birthplace (State or Foreign Country)
Washington DC | | 10a. State
Maryland | | 10b. County
Prince George | | 10c. City, Town or Location
Clinton | |
| Usual Residence of Decedent | | 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 10e. Street and Number
6507 Pin Oak Court | | 10f. Zip Code
20735 | | |
| 10g. Citizen of What Country?
United States | | 11. Marital Status
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | |
| 14. Race - American Indian, Black, White, etc.
Specify: Black | | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 Collage (1-4or 5+) 12 | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Lab Technician | | 16b. Kind of Business/Industry
Food & Drug Adm. | | |
| 17. Father's Name (First, Middle, Last)
French L. Burke | | 18. Mother's Name (First, Middle, Maiden Surname)
Deloise G. Johnson | | 19a. Informant's Name/Relationship (Type, Print)
Madelein Burke | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
6507 Pin Oak Court, Clinton, Maryland 20735 | | |
| 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Harmony Memorial Park | | 20c. Location - City or Town, State
May 21, 1996
Hyattsville, Maryland | | 21. Signature of Funeral Service Licensee
Lee Funeral Home, Inc 6633 Old Alexandria Ferry Rd, Clinton, Md 20735 | | |
| 22. Name and Address of Facility
Lee Funeral Home, Inc 6633 Old Alexandria Ferry Rd, Clinton, Md 20735 | | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
a. Metastatic Colon Cancer
Due to (or as a consequence of):
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of): | | Approximate Interval Between Onset and Death
2 years | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | |
| 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 28d. Describe how Injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | |
| 29b. Signature and title of certifier
R.M. Nedzala | | 29c. License number
D07348 | | 29d. Date signed (Month, Day, Year)
5-20-96 | | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Robert M. Nedzala, M.D. 11701 Livingston Rd, #101, Fort Washington, MD 20744 | | |
| 31. Date filed (Month, Day, Year)
MAY 21 1996 | | 32. Registrar's Signature
Julia Dawson-Randall | | State Registrar | | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 15976

| | | | | | | | | | | | | |
|---|--|--|---|--|--|--|---|--|--|--|--|---|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
<i>Grace Catherine Blansfield</i> | | | | | | 2. Date of Death
Month Day Year
<i>May 13 1996</i> | | | 3. Time of Death
<i>8:50 PM</i> | | |
| | 4a. Facility Name (If not institution, give street and number)
Harford Memorial Hospital | | | | | | 4b. City, Town, or Location of Death
Havre de Grace | | | 4c. County of Death
Harford | | |
| Funeral
Director | 5. Social Security Number
213-16-4706 | | 6. Sex
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday)
79 Yrs. | | If Under 1 Year
Months Days | | If Under 24 Hrs.
Hours Min. | | 8. Date of Birth (Month, Day, Year)
02-12-1917 | 9. Birthplace (State or Foreign Country)
MD |
| | Usual Residence of Decedent | | | | | | | | | | | |
| 10a. State
MD | | | 10b. County
Harford | | | 10c. City, Town or Location
Havre de Grace | | | 10d. Inside City Limits
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | |
| 10e. Street and Number
314 N. Stokes Street | | | | | | 10f. Zip Code
21078 | | | 10g. Citizen of What Country?
USA | | | |
| 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc.
Specify: White | | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 6 College (1-4or 5+) College (1-4or 5+) | | | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Homemaker | | | 16b. Kind of Business/Industry
Home | | | |
| 17. Father's Name (First, Middle, Last)
Harry Russell | | | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Mable Hughes | | | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
Mr. Earl Blansfield - Son | | | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
3609-A Birch Street, Dover, DE 19901 | | | | | | |
| 20a. Method of Disposition
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Spesutia Cemetery | | | | Date
5/17/96 | | 20c. Location - City or Town, State
Perryman, Maryland | | |
| 21. Signature of Funeral Service Licensee
<i>William S. Smith</i> | | | | | | 22. Name and Address of Facility
Mitchell-Smith Funeral Home, P.A.
Havre de Grace, MD 21078-3197 | | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | | | | | | Approximate Interval Between Onset and Death
7 days |
| Immediate Cause (Final disease or condition resulting in death)
e. <i>Acute myocardial infarction</i>
Due to (or as a consequence of): | | | | | | | | | | | | |
| b. <i>arteriosclerosis heart disease</i>
Due to (or as a consequence of): | | | | | | | | | | | | |
| c.
Due to (or as a consequence of): | | | | | | | | | | | | |
| 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | | | | | | | | | | |
| 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
<i>Carcinoma Bladder</i>
<i>Scabets Mellitus</i> | | | | | | | | | | | | |
| 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one)
Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | | |
| 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide
5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | | |
| | | | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | |
| 29a. Certifier (Check only one)
1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | | | | | |
| 29b. Signature and title of certifier
<i>William H. W. Smith</i> | | | | | | 29c. License number
D 11491 | | | 29d. Date signed (Month, Day, Year)
5/13/96 | | | |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) | | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
MAY 15 1996 | | | | 32. Registrar's Signature
<i>John Davidson-Randall</i> | | | | | | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit

E

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 15978

Certificate of Death

Reg. No.

| | | | | | | | | | | |
|--|---|--|---|--|--|--|--|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
RICHARD BRUCE BROWN | | | | 2. Date of Death
Month Day Year
MAY 11, 1996 | | | | 3. Time of Death
2:45 AM | |
| | 4a. Facility Name (If not institution, give street and number)
Washington Adventist Hospital | | | | 4b. City, Town, or Location of Death
Takoma Park | | | | 4c. County of Death
Montgomery | |
| Funeral
Director | 5. Social Security Number
219-78-5386 | | 6. Sex
1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 7. Age (In yrs. last birthday)
34 Yrs. | | 8. Date of Birth (Month, Day, Year)
Oct. 26, 1961 | | 9. Birthplace (State or Foreign Country)
Illinois | |
| | Usual Residence of Decedent | | | | | | | | | |
| To Be Completed by Funeral Director | 10a. State
Maryland | | 10b. County
Montgomery | | 10c. City, Town or Location
Damascus | | | | 10d. Inside City Limits
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | |
| | 10e. Street and Number
10605 Shasta Court | | | | 10f. Zip Code
20882 | | 10g. Citizen of What Country?
USA | | | |
| | 11. Marital Status
1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | | 14. Race - American Indian, Black, White, etc.
Specify: White | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) College (1-4 or 5+)
4 | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Director of Sales and Marketing | | | | 16b. Kind of Business/Industry
Banking | |
| | 17. Father's Name (First, Middle, Last)
O. Robert Brown, Jr. | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Mary Helen Elliott | | | | | |
| | 19a. Informant's Name/Relationship (Type, Print)
O. Robert Brown, Jr. | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
12118 Hunters Lane, Rockville, Maryland 20852 | | | | | |
| | 20a. Method of Disposition
1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Metropolitan Crematory | | Date
5/18/96 | | 20c. Location - City or Town, State
Alexandria, Virginia | | | |
| | 21. Signature of Funeral Service Licensee
<i>James J. Collins</i> | | | | 22. Name and Address of Facility
Francis J. Collins Funeral Home, Inc.
500 University Blvd. W. Silver Spring, MD 20901 | | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. Respiratory Failure
Due to (or as a consequence of):
b. metastatic Sarcoma
Due to (or as a consequence of):
c. mediastinal Germ Cell Tumor
Due to (or as a consequence of):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Approximate Interval Between Onset and Death
3 wks
1 year
2 1/2 years | | | | | | | | | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | | |
| 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | | | | | | | | |
| 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | | | | |
| To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | |
| | 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide
5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | |
| | | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| | 29a. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Physician 2 <input type="checkbox"/> Medical Examiner | | 29b. Signature and title of certifier
<i>Thomas A. Bensinger MD</i> | | | | | | | |
| | | | 29c. License number
D08754 | | 29d. Date signed (Month, Day, Year)
May 12, 1996 | | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Thomas A. Bensinger MD 7525 Greenway Cir Dr. Greenbelt MD 20770 | | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
MAY 15, 1996 | | 32. Registrar's Signature
<i>John Andrew Radell</i> | | | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Registrar and Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 15979

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

SARAH

BROMBERG

2. Date of Death

May 12, 1996

3. Time of Death

6:45 PM

Funeral
Director

4a. Facility Name (If not institution, give street and number)

MONTGOMERY GENERAL HOSPITAL

4b. City, Town, or Location of Death

OLNEY

4c. County of Death

MONTGOMERY

5. Social Security Number

305-48-7512

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

87 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

DEC. 18, 1908

9. Birthplace (State or Foreign Country)

MICHIGAN

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

MONTGOMERY

10c. City, Town or Location

SILVER SPRING

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

14508 HOMECREST ROAD #214

10f. Zip Code

20906

10g. Citizen of What Country?

UNITED STATES

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No, if Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

HOMEMAKER

16b. Kind of Business/Industry

OWN HOME

17. Father's Name (First, Middle, Last)

ABRAHAM RAVITCH

18. Mother's Name (First, Middle, Maiden Surname)

JENNIE KATZ

19a. Informant's Name/Relationship (Type, Print)

JUDY KIRSCH (DAUGHTER)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

10408 BURNT EMBER DRIVE - SILVER SPRING, MD. 20903

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

JUDEAN MEMORIAL GARDENS

Date

5/14/96

20c. Location - City or Town, State

OLNEY, MARYLAND

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

DANZANSKY-GOLDBERG MEMORIAL CHAPELS, INC.
1170 ROCKVILLE PIKE - ROCKVILLE, MARYLAND 20852

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

CONGESTIVE HEART FAILURE

Approximate Interval Between Onset and Death

Years

Due to (or as a consequence of):

Due to (or as a consequence of):

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

COPD; Polycythemia vera,
chronic renal failure

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician2 ☐ Medical Examiner

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D38457

29d. Date signed (Month, Day, Year)

MAY 12, 1996

30. Name and address of person who completed cause of death (item 23a) (Type, Print)

N. Goyal MD 1811 Prince Philip Dr Olney MD 20832

31. Date filed (Month, Day, Year)

MAY 17 1996

32. Registrar's Signature

John Andrew Randall

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or item 29a-4 shows any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

3

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 15980

Certificate of Death

Reg. No.

| | | | | | | | | |
|--|---|---|---|--|---|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Elsie Burgess Blandford | | | | 2. Date of Death
Month Day Year
May 11 1996 | | 3. Time of Death
12:45 PM | |
| | 4a. Facility Name (If not Institution, give street and number)
Sacred Heart Home | | | | 4b. City, Town, or Location of Death
Hyattsville | | 4c. County of Death
Prince George's | |
| Funeral
Director | 5. Social Security Number
228-40-9112 | 6. Sex
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)
92 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth (Month, Day, Year)
Jul. 27, 1903 | | 9. Birthplace (State or Foreign Country)
Virginia |
| | Usual Residence of Decedent | | | | | | | |
| 10a. State
Maryland | | 10b. County
Prince George's | | 10c. City, Town or Location
Riverdale | | 10d. Inside City Limits
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | |
| 10e. Street and Number
5906 60th Avenue | | | | 10f. Zip Code
20743 | | 10g. Citizen of What Country?
U.S.A. | | |
| 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: White | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (1-4or 5+) 12 | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Clerk | | 16b. Kind of Business/Industry
Health and Safety Services | | |
| 17. Father's Name (First, Middle, Last)
Arthur Burgess | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Clair Clauder | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
Charles F. Murray | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
5906 60th Avenue Riverdale, Maryland 20743 | | | | |
| 20a. Method of Disposition
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Cedar Hill Cemetery | | Data
5/15/96 | | 20c. Location - City or Town, State
Suitland, Maryland | | |
| 21. Signature of Funeral Service Licensee
 | | | | 22. Name and Address of Facility
Francis J. Collins Funeral Home, Inc.
500 University Blvd., W. Sil. Spr., MD 20901 | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. <u>INTESTINAL OBSTRUCTION WITH SEPSIS</u>
Due to (or as a consequence of):

b.
Due to (or as a consequence of):

c.
Due to (or as a consequence of):

d.
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | | Approximate Interval Between Onset and Death
DAYS |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
<u>SENILE DEMENTIA</u> | | | | | | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | |
| | | | | | | 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | |
| | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | |
| 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death
1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation
2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined
3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred |
| | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | |
| 29a. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier
 | | | | | | |
| | | 29c. License number
022780 | | 29d. Date signed (Month, Day, Year)
5/13/96 | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Peter M Schissler MD 7500 Greenway Ctr Dr. Greenbelt Md 20770 | | | | | | | | |
| 31. Date filed (Month, Day, Year)
MAY 15 1996 | | 32. Registrar's Signature
 | | | | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit




State
Registrar



96 15981

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
GEORGE, ARTHUR, BROMLEY | | | | 2. DATE OF DEATH
MONTH 05 DAY 11 YEAR 96 | | 3. TIME OF DEATH
3:15 AM | |
| 4. SOCIAL SECURITY NUMBER
597-58-3643 | | 5. SEX
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
94 YRS. | | 7. DATE OF BIRTH (Month, Day, Year)
04-23-02 | |
| 8. FACILITY NAME (If not institution, give street and number)
MEDLANTIC MANOR AT LAYHILL | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
Silver Spring | | 9c. COUNTY OF DEATH
MONT. | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE
none | | 10b. COUNTY
none | | 10c. CITY, TOWN OR LOCATION
Washington, D.C. | | 10d. INSIDE CITY LIMITS?
<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER
2336 Nebraska Avenue, N.W. | | | | 10f. ZIP CODE
20016 | | 10g. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 11. MARITAL STATUS
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify:
white | |
| 15. DECEDENT'S EDUCATION
(Specify only highest grade completed)
Elementary/Secondary (0-12) 12
College (1-4 or 5+) ice dealer | | 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.)
ice dealer | | 16b. KIND OF BUSINESS/INDUSTRY
ice company | | | |
| 17. FATHER'S NAME (First, Middle, Last)
Arthur Bromley | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Minnie I. Stone | | | |
| 19a. INFORMANT'S NAME (Type/Print)
Andrew C. Fretz | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
8607 Kerry Lane, Springfield, Va. 22152 | | | |
| 20a. METHOD OF DISPOSITION
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
Cedar Hill Cemetery May 15, 96 | | 20c. LOCATION — City or Town, State
Suitland, Md. | | 22. NAME AND ADDRESS OF FACILITY
DeVol Funeral Home
2222 Wisconsin Ave., N.W., Wash., D.C. 20007 | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
 | | | | 22. NAME AND ADDRESS OF FACILITY
DeVol Funeral Home
2222 Wisconsin Ave., N.W., Wash., D.C. 20007 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
IMMEDIATE CAUSE (Final disease or condition resulting in death) →
basal cell carcinoma
DUE TO (OR AS A CONSEQUENCE OF):
prostatitis
DUE TO (OR AS A CONSEQUENCE OF):
colonic polyps
DUE TO (OR AS A CONSEQUENCE OF):
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | Approximate interval Between Onset and Death
9 years
4 years | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 24a. WAS AN AUTOPSY PERFORMED?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
<input type="checkbox"/> YES <input type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA
OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation
<input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M | | 28c. INJURY AT WORK?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | 28g. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one)
<input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
 | | | | 29c. LICENSE NUMBER
D32 817 | | 29d. DATE SIGNED (Month, Day, Year)
5/13/96 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
12106 Georgia Ave., Wheaton, Maryland | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
MAY 15' 1996 | | | | 32. REGISTRAR'S SIGNATURE
 | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 15982

Certificate of Death

Reg. No.

| | | | | | | | | |
|---|---|--|---|--|---|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
<i>MARIA Mercedes BASORA</i> | | | | 2. Date of Death
Month <i>May</i> Day <i>10</i> Year <i>1996</i> | | 3. Time of Death
<i>0905A</i> | |
| | 4a. Facility Name (If not institution, give street and number)
<i>SHADY GROVE ADVENTIST HOSPITAL</i> | | | | 4b. City, Town, or Location of Death
<i>ROCKVILLE</i> | | 4c. County of Death
<i>MONTGOMERY</i> | |
| Funeral
Director | 5. Social Security Number
<i>581-88-1767</i> | | 8. Sex
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday)
<i>85</i> Yrs. | | 6. Date of Birth (Month, Day, Year)
<i>May 11, 1910</i> | |
| | 9. Birthplace (State or Foreign Country)
<i>New York</i> | | 10a. State
<i>Washington, D.C.</i> | | 10b. County | | 10c. City, Town or Location | |
| To Be Completed by Funeral Director | 10e. Street and Number
<i>4419 Argyle Terrace, NW</i> | | | | 10f. Zip Code
<i>20011</i> | | 10g. Citizen of What Country?
<i>United States</i> | |
| | 11. Marital Status
1 <input type="checkbox"/> Navar Married 2 <input type="checkbox"/> Married
3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No Specify: <i>Puerto Rican</i> | | 14. Race - American Indian, Black, White, etc.
Specify: <i>White</i> | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) <i>2</i> College (1-4 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
<i>Realtor</i> | | 16b. Kind of Business/Industry
<i>Real Estate</i> | | | |
| | 17. Father's Name (First, Middle, Last)
<i>Marcelino Sola</i> | | | | 18. Mother's Name (First, Middle, Maiden Surname)
<i>Francisca Fulladosa</i> | | | |
| | 19a. Informant's Name/Relationship (Type, Print)
<i>Adrian A. Basora</i> | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
<i>4419 Argyle Terrace, NW, Washington, DC 20011</i> | | | |
| | 20a. Method of Disposition
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
<i>St. Charles Cemetery</i> | | Date
<i>5-15-96</i> | | 20c. Location - City or Town, State
<i>Farmingdale, New York</i> | |
| | 21. Signature of Funeral Service Licensee
<i>Eileen L. Rapp</i> | | | | 22. Name and Address of Facility
<i>Rapp Funeral Services, P. A.
933 Gist Avenue, Silver Spring, MD 20910</i> | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

a. <i>Aspiration Pneumonia</i>
Due to (or as a consequence of):
b. <i>Cerebral Vascular Accident</i>
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Approximate Interval Between Onset and Death
<i>3 DAYS</i>
<i>4 DAYS</i> | | | | | | | |
| | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | | | | | |
| | 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | |
| To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate. | 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | |
| | 26. Place of Death (Check only one)
Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | |
| | 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide
5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
<i>M</i> | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| | 28d. Describe how injury occurred | | | | 28e. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| To Be Completed by Physician/Medical Examiner | 29a. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | |
| | 29b. Signature and title of certifier
<i>Kenan Hudson, MD</i> | | | | 29c. License number
<i>D41866</i> | | 29d. Date signed (Month, Day, Year)
<i>MAY 10, 1996</i> | |
| | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
<i>KANAN HUDHUB 481 N. FREDERICK AVE, GAITHERSBURG, MD 20877</i> | | | | | | | |
| State Registrar | 31. Date filed (Month, Day, Year)
<i>MAY 14 1996</i> | | | | 32. Registrar's Signature
<i>John Hudson</i> | | | |

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 15983

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Evelyn Connolly BARCUS

2. Date of Death

May 9, 1996

Day Year

3. Time of Death

1:54AM

4a. Facility Name (If not institution, give street and number)

Doctors Community Hospital

4b. City, Town, or Location of Death

Lanham

4c. County of Death

Prince George's

Funeral
Director

5. Social Security Number

212-09-5584

6. Sex

1 ☐ M 2 ☒ F

7. Age (in yrs. last birthday)

82

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Nov. 23, 1913

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10e. State

Maryland

10b. County

Prince George's

10c. City, Town or Location

Greenbelt

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

2T Gardenway

10f. Zip Code

20770

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.Specify:
White

To Be Completed by Funeral Director

15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
12

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

James Edward Connolly

18. Mother's Name (First, Middle, Maiden Surname)

Mary Elizabeth Boyle

19a. Informant's Name/Relationship (Type, Print)

Mary Barcus Smith

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1272 Lavall Drive Davidsonville, Maryland 21035

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

St. Peter's Cemetery

Date

5/13/96

20c. Location - City or Town, State

Queenstown, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Francis J. Collins Funeral Home, Inc.

500 University Blvd., W. Sil. Spr., MD 20901

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)a. *sepsis*
Due to (or as a consequence of):Approximate
Interval Between
Onset and Death

5 days

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Lastb. *perforated gastric ulcer*
Due to (or as a consequence of):

5 days

c. *severe hemorrhagic gastritis*
Due to (or as a consequence of):

2 days

d. *renal failure*
Due to (or as a consequence of):

30 days

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
Investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide
4 ☐ Homicide28a. Date of Injury
(Month, Day Year)28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

29c. License number

D00483

29d. Date signed (Month, Day, Year)

5-10-96

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

115 CENTER HWY, GREENBELT, MD, 20770 Dr. Till Bergemann

31. Date filed (Month, Day, Year)

MAY 13 1996

32. Registrar's Signature

State
Registrar

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

7

96 15984

Amended #6, 5/14/96, MRT, Montgomery County

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | |
|---|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
CYNTHIA VIRGINIA BRISCO | | 2. DATE OF DEATH
MONTH DAY YEAR
MAY 11 1996 | | 3. TIME OF DEATH
0850 A M | |
| 4. SOCIAL SECURITY NUMBER
213-10-8863 | | 5. SEX
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (in yrs. last birthday)
78 77 YRS. | |
| 7. DATE OF BIRTH (Month, Day, Year)
July 31, 1918 | | 8. BIRTHPLACE (State or Foreign Country)
Maryland | | | |
| 9a. FACILITY NAME (If not institution, give street and number)
7 Olivewood Court | | 9b. CITY, TOWN OR LOCATION OF DEATH
Greenbelt | | 9c. COUNTY OF DEATH
Prince George's | |
| 10a. STATE
Maryland | | 10b. COUNTY
Prince George's | | 10c. CITY, TOWN OR LOCATION
Greenbelt | |
| 10d. INSIDE CITY LIMITS?
1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 10e. STREET AND NUMBER
7 Olivewood Court | | 10f. ZIP CODE
20770 | |
| 10g. CITIZEN OF WHAT COUNTRY?
United States | | 11. MARITAL STATUS
1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | |
| 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify:
white | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (1-4 or 5+) 2 | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
homemaker | | 16b. KIND OF BUSINESS/INDUSTRY
own home | |
| 17. FATHER'S NAME (First, Middle, Last)
Daniel William Hobbs, Sr. | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Sophia Sanders Hobbs | | | |
| 19a. INFORMANT'S NAME (Type/Print)
Kenneth B. Brisco | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
7 Olivewood Court, Greenbelt, Maryland 20770 | | | |
| 20a. METHOD OF DISPOSITION
1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input checked="" type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
U H U H S | | 20c. LOCATION — City or Town, State
5-13 Bethesda, Maryland | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
<i>Ethan S. Rapp</i> | | 22. NAME AND ADDRESS OF FACILITY
Rapp Funeral Services, P.A.
933 Gist Avenue, Silver Spring, MD 20910 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. SMALL CELL LUNG CANCER
DUE TO (OR AS A CONSEQUENCE OF):
b. Congestive Heart failure
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.
Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | Approximate Interval Between Onset and Death |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | 24a. WAS AN AUTOPSY PERFORMED?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residential 6 <input checked="" type="checkbox"/> Other (Specify) HOSPICE | | | |
| 27. MANNER OF DEATH
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation
2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined
3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28c. INJURY AT WORK?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| 29a. CERTIFIER (Check only one)
1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
<i>Rueben Bullock (CIV)</i> | | 29c. LICENSE NUMBER
IL 036-088867 | | 29d. DATE SIGNED (Month, Day, Year)
5/13/96 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
NNMC, Wisconsin Ave, Bethesda, MD. | | | | | |
| 31. DATE FILED (Month, Day, Year)
MAY 14 1996 | | 32. REGISTRAR'S SIGNATURE
<i>John Davidson-Randall</i> | | | |

TO BE COMPLETED BY FUNERAL DIPECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 6 and 7 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

3

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

ANGEL

LEE

BARTON

BURTON

2. Date of Death

Month Day Year

MAY 6 1996

3. Time of Death

12:10 AM

Funeral
Director

4a. Facility Name (If not institution, give street and number)

1437 NORTH BOND STREET

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

5. Social Security Number

220-86-0802

6. Sex

1 ☐ M ☒ F

7. Age (In yrs. last birthday)

29 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

June 3, 1966

9. Birthplace (State or Foreign Country)

Missouri

Usual Residence of Decedent

10a. State

Maryland

10b. County

Prince George's

10c. City, Town or Location

Riverdale

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

5611 59th Avenue

10f. Zip Code

20737

10g. Citizen of What Country?

United States

11. Marital Status

☒ Never Married 2 ☐ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

unemployed

16b. Kind of Business/Industry

none

17. Father's Name (First, Middle, Last)

Gary Keith Barton

18. Mother's Name (First, Middle, Maiden Surname)

Linda Jean Windsor

19a. Informant's Name/Relationship (Type, Print)

Linda Jean Windsor (mother)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

9511 East 33rd. Street Independence, Missouri 64052

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Metropolitan Crematory

Date

5/10/1996

20c. Location - City or Town, State

Alexandria, Virginia

21. Signature of Funeral Service Licensee

Donald V. Borgwardt

22. Name and Address of Facility

Donald V. Borgwardt Funeral Home, P.A.

4400 Powder Mill Road Beltsville, Maryland 20705

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. *Fatty Liver* NARCOTIC AND ALCOHOL INTOXICATION

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

FATTY LIVER

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☒ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☒ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☒ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide
4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

5-5-96

28b. Time of injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

David R. Fowler

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

MAY 6, 1996

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

David R. Fowler

111 Penn Street, Baltimore, Maryland 21201

31. Date filed (Month, Day, Year)

MAY 14 1996

32. Registrar's Signature

*John Davidson-Rodell*State
Registrar

Baltimore, Maryland 21215-0020

Baltimore, Maryland 21215-0020
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

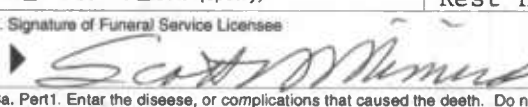
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 15986

Certificate of Death

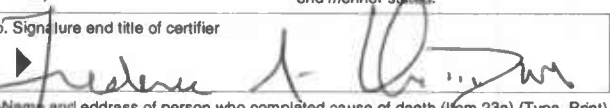
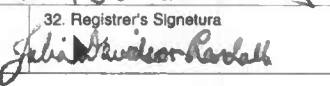
Reg. No.

| | | | | | | | | | | |
|---|--|---|--|--|--|--|---|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Craig Alan CROWL | | | | | | 2. Date of Death
Month May Day 22 Year 1996 | | 3. Time of Death
3:10 p.m. | |
| | 4a. Facility Name (If not institution, give street and number)
218 Division Avenue | | | | | | 4b. City, Town, or Location of Death
Hagerstown | | 4c. County of Death
Washington | |
| Funeral
Director | 5. Social Security Number
215-21-5425 | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday)
24 Yrs. | | 8. Date of Birth (Month, Day, Year)
May 19 1972 | | 9. Birthplace (State or Foreign Country)
Washington D.C. | |
| | Usual Residence of Decedent | | | | | | | | | |
| 10a. State
Maryland | | 10b. County
Washington | | 10c. City, Town or Location
Hagerstown | | | | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | |
| 10e. Street and Number
218 Division Avenue | | 10f. Zip Code
21740 | | 10g. Citizen of What Country?
U.S.A. | | | | | | |
| 11. Marital Status
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
If Yes, Give Year or Dates 1990-1996 | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | | 14. Race - American Indian, Black, White, etc.
Specify: White | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (1-4or 5+) 0 | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Sergeant | | | | 16b. Kind of Business/Industry
Military | | | | |
| 17. Father's Name (First, Middle, Last)
John Lee Crowl | | | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Marjorie Ann Ferguson | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
Teresa Crowl | | | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
218 Division Avenue Hagerstown, Maryland 21740 | | | | |
| 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Rest Haven Cemetery | | Date
5/25/96 | | 20c. Location - City or Town, State
Hagerstown, Maryland | | | | |
| 21. Signature of Funeral Service Licensee
 | | | | | | 22. Name and Address of Facility
Minnich Funeral Home
415 E. Wilson Boulevard Hagerstown, Md. 21740 | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. <u>Adrenal Carcinoma</u>
Due to (or as a consequence of):

Sequitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. _____
Due to (or as a consequence of):

c. _____
Due to (or as a consequence of):

d. _____ | | | | | | Approximate Interval Between Onset and Death
12 months | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | |
| | | | | | | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | |
| | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | | |
| | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier
 | | 29c. License number
023623 | | 29d. Date signed (Month, Day, Year)
5/24/96 | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Frederic H. Kuss III MD 1799 Howell Rd Hagerstown Md | | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
MAY 24 1996 | | 32. Registrar's Signature
 | | | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

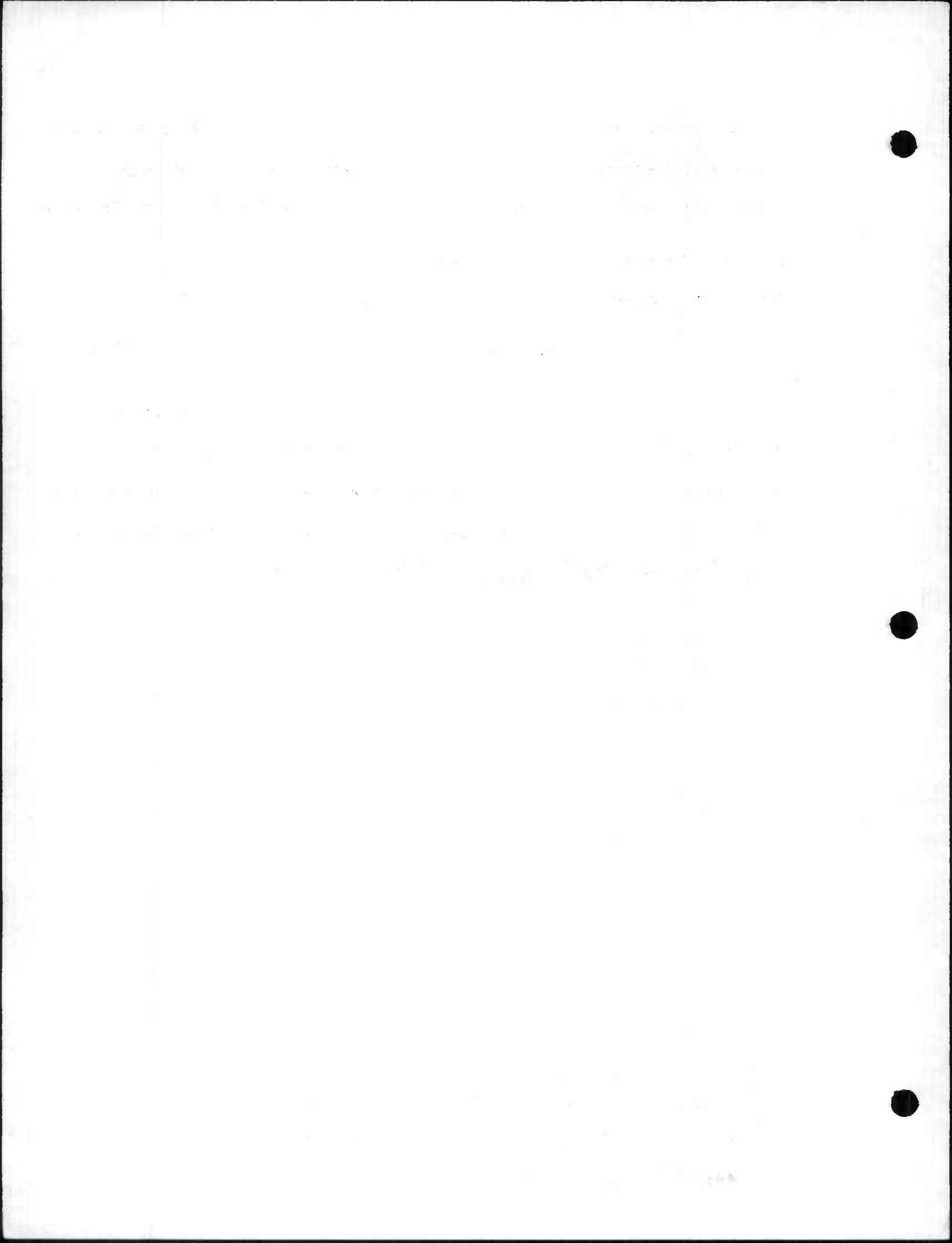
Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director



Medical Certification: To Be Completed by Physician/Medical Examiner



96 15987

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
Katharine (unknown) Coble | | | | 2. DATE OF DEATH
MONTH DAY YEAR
May 20, 1996 | | 3. TIME OF DEATH
1:35 P M | |
| 4. SOCIAL SECURITY NUMBER
160-01-5627 | | 5. SEX
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
83 YRS. | | 7. DATE OF BIRTH (Month, Day, Year)
Aug 8 1912 | |
| 8. BIRTHPLACE (State or Foreign Country)
Pennsylvania | | | | 9a. FACILITY NAME (If not institution, give street and number)
Western Maryland Hospital | | 9b. CITY, TOWN OR LOCATION OF DEATH
Hagerstown | |
| 9c. COUNTY OF DEATH
Washington | | | | 10a. STATE
Maryland | | 10b. COUNTY
Washington | |
| 10c. CITY, TOWN OR LOCATION
Hagerstown | | | | 10d. INSIDE CITY LIMITS?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 10e. STREET AND NUMBER
Route 8 | |
| 10f. ZIP CODE
21740 | | | | 10g. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 11. MARITAL STATUS
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR OATES | | | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify:
White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (1-4 or 5+) 0 | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
Secretary | | 16b. KIND OF BUSINESS/INDUSTRY
Aircraft | |
| 17. FATHER'S NAME (First, Middle, Last)
Harry P. Proud | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Julia M. (Unknown) | | | |
| 19a. INFORMANT'S NAME (Type/Print)
Lee Downey | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
11211 Kemps Mill Road Williamsport, Md. 21795 | | | |
| 20a. METHOD OF DISPOSITION
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
Norland Cemetery 5/22/96 | | 20c. LOCATION — City or Town, State
Chambersburg, Pa. | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
 | | | | 22. NAME AND ADDRESS OF FACILITY
Minnich Funeral Home
415 E. Wilson Blvd. Hagerstown, Md. 21795 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Pneumonia
DUE TO (OR AS A CONSEQUENCE OF):
b. Subarachnoid Hemorrhage
DUE TO (OR AS A CONSEQUENCE OF):
c. _____
DUE TO (OR AS A CONSEQUENCE OF):
d. _____
Approximate Interval Between Onset and Death since 5/17/96 1988
Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Congestive Heart Failure, Coma | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA
OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation
2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined
3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M | | 28c. INJURY AT WORK?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURED | | | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. CERTIFIER (Check only one)
1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
Fe U. Porciuncula, M.D. | | | | 29c. LICENSE NUMBER
D12642 | | 29d. DATE SIGNED (Month, Day, Year)
5/20/96 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
Fe U. Porciuncula, M.D. 1500 Pennsylvania Avenue
Western Maryland Center, Hagerstown, MD 21742 | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
MAY 22 1996 | | | | 32. REGISTRAR'S SIGNATURE
 | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

D

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 15988

Certificate of Death

Reg. No.

| | | | | | | | | |
|--|--|---|--|--|--|--|---|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Thomas Tennill Christian Jr. | | | | 2. Date of Death
Month Day Year
May 19, 1996 | | 3. Time of Death
10:05 A.M. | |
| | 4a. Facility Name (If not institution, give street and number)
Friederick Memorial Hospital | | | | 4b. City, Town, or Location of Death
Friederick | | 4c. County of Death
Friederick | |
| Funeral
Director | 5. Social Security Number
459-12-5543 | | 6. Sex
1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 7. Age (In yrs. last birthday)
77 Yrs. | | 8. Date of Birth (Month, Day, Year)
June 8, 1918 | |
| | 9. Birthplace (State or Foreign Country)
Texas | | 10a. State
Texas | | 10b. County
Tom Green | | 10c. City, Town or Location
San Angelo | |
| 10d. Inside City Limits
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 10e. Street and Number
3841 High Meadow Drive | | 10f. Zip Code
76904 | | 10g. Citizen of What Country?
USA | | |
| 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No
If Yes, Give Year or Date: World War II | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: White | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) College (1-4 or 5+)
4 | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Range Conservationist | | 16b. Kind of Business/Industry
U. S. Government | | | | |
| 17. Father's Name (First, Middle, Last)
Thomas Tennill Christian, Sr. | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Jennie B. Sublett | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
Richard T. Christian | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
3512 Cemetery Circle - Knoxville, MD 21758 | | | | |
| 20a. Method of Disposition
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Longhaven Mem. Gar. | | 20c. Location - City or Town, State
5/17 San Angelo, Texas | | | | |
| 21. Signature of Funeral Service Licensee
Barbara A. Williams, Owner | | | | 22. Name and Address of Facility
John T. Williams Funeral Home
Brunswick, MD 21716 | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
Immediate Cause (Final disease or condition resulting in death)
a. METABOLIC ENCEPHALOPATHY
Due to (or as a consequence of):
b. HEPATIC FAILURE
Due to (or as a consequence of):
c. METASTATIC COLON CANCER, ADENOCARCINOMA
Due to (or as a consequence of):
d.
Approximate Interval Between Onset and Death
1 DAY
1 WEEK
8 MONTHS | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | |
| | | | | | | 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | |
| | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | |
| 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide
5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | |
| | | 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28d. Describe how injury occurred | | | | |
| 29a. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier
Bryan M. O'Connor | | 29c. License number
D31761 | | 29d. Date signed (Month, Day, Year)
5/19/96 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Bryan M. O'Connor MD 501 W. SEVENTH ST, FREDERICK MD 21701 | | | | | | | | |
| 31. Date filed (Month, Day, Year)
MAY 20 1996 | | 32. Registrar's Signature
John Shuler-Randall | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 501-251-5015.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene
Certificate of Death

96 15989

Reg. No.

| | | | | | | | | | | |
|---|--|--|---|--|--|---|--|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
TIMOTHY HAHN CLARK | | | | | 2. Date of Death
Month Day Year
May 12, 1996 | | 3. Time of Death
12:30 P.M. | | |
| | 4e. Facility Name (If not institution, give street and number)
4710 Mt. Zion Rd. | | | | | 4b. City, Town, or Location of Death
Frederick | | 4c. County of Death
Frederick | | |
| Funeral
Director | 5. Social Security Number
216-76-9316 | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)
36 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth (Month, Day, Year)
Dec. 20, 1959 | | 9. Birthplace (State or Foreign Country)
Maryland | |
| | Usual Residence of Decedent | | | | | | | | | |
| 10a. State
Maryland | | | 10b. County
Frederick | | 10c. City, Town or Location
Frederick | | | 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 10e. Street and Number
4710 Mt. Zion Rd. | | | | | 10f. Zip Code
21703 | | 10g. Citizen of What Country?
United States | | | |
| 11. Marital Status
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc.
Specify: White | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (1-4or 5+) | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Private Investigator | | | 18b. Kind of Business/Industry
Investigative Security / | | | | |
| 17. Father's Name (First, Middle, Last)
Lynwood Calvin Clark | | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Patricia Smith | | | | | |
| 19e. Informant's Name/Relationship (Type, Print) (wife)
Regina (Fitzpatrick) Clark | | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
4710 Mt. Zion Rd./ Frederick, Md. 21703 | | | | | |
| 20e. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Mount Olivet Cemetery | | | Date
5/15/96 | | 20c. Location - City or Town, State
Frederick, Maryland | | |
| 21. Signature of Funeral Service Licensee
 | | | | | 22. Name and Address of Facility
Stauffer Funeral Home
1621 Opossumtown Pike/ Frederick, Md. 21702 | | | | | |
| 23a. Pertinent. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

PRIMARY BRAIN TUMOR | | | | | | | | | Approximate Interval Between Onset and Death
13 months | |
| Immediate Cause (Final disease or condition resulting in death)

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

Due to (or as a consequence of):

Due to (or as a consequence of): | | | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | |
| | | | | | | | 24e. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | |
| | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No | | | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | | 28e. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input type="checkbox"/> No | | 28d. Describe how Injury occurred | |
| | | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | |
| 29e. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | | | |
| 29b. Signature and title of certifier
 | | | 29c. License number
D26609 | | | 29d. Date signed (Month, Day, Year)
5-13-96 | | | | |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)
Dr. Joseph Ashwal, 56 Thomas Johnson Dr./ Frederick, Md. 21702 | | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
MAY 13 1996 | | | 32. Registrar's Signature
 | | | | | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or item 23a or 23e show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

State
Registrar

96 15990

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | | | | | | |
|--|--|---|--|---|--|---|---|--|-----------------------------------|--------------|---------------------|----------------|----------------------------------|--------------|
| 1. DECEDENT'S NAME (First, Middle, Last)
John Ralph Clayton | | | | 2. DATE OF DEATH
MONTH May DAY 11 , YEAR 1996 | | 3. TIME OF DEATH
6:00 A M | | | | | | | | |
| 4. SOCIAL SECURITY NUMBER
223-14-1995 | | 5. SEX
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | 6. AGE (In yrs. last birthday)
88 YRS. | IF UNDER 1 YEAR
MONTHS 0 DAYS 0 | IF UNDER 24 HRS.
HOURS 0 MIN. 0 | 7. DATE OF BIRTH
(Month, Day, Year)
April 6, 1908 | | | | | | | | |
| 8. BIRTHPLACE (State or Foreign Country)
North Carolina | | | | | | | | | | | | | | |
| 9a. FACILITY NAME (If not institution, give street and number)
11711 Kingstead Road | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
Damascus | | 9c. COUNTY OF DEATH
Montgomery | | | | | | | | |
| RESIDENCE OF DECEDENT | | | | | | | | | | | | | | |
| 10a. STATE
Maryland | | 10b. COUNTY
Montgomery | | 10c. CITY, TOWN OR LOCATION
Damascus | | 10d. INSIDE CITY LIMITS?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | | | | | |
| 10e. STREET AND NUMBER
11711 Kingstead Road | | | | 10f. ZIP CODE
20872 | | 10g. CITIZEN OF WHAT COUNTRY?
United States | | | | | | | | |
| 11. MARITAL STATUS
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify: White | | | | | | | | |
| 15. DECEDENT'S EDUCATION
(Specify only highest grade completed)
Elementary/Secondary (0-12)
8 | | 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.)
Landscaper | | 16b. KIND OF BUSINESS/INDUSTRY
Landscaping | | | | | | | | | | |
| 17. FATHER'S NAME (First, Middle, Last)
John Clayton | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Maude Lanning | | | | | | | | | | |
| 19a. INFORMANT'S NAME (Type/Print)
Martha Ferne Dale | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
26108 Cornor Drive, Damascus, Md. 20872 | | | | | | | | | | |
| 20a. METHOD OF DISPOSITION
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
Mountain View 5/14/96 | | 20c. LOCATION — City or Town, State
Damascus, Md. | | | | | | | | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
<i>Olin L. Molesworth</i> | | 22. NAME AND ADDRESS OF FACILITY
Olin L. Molesworth, P.A.
26401 Ridge Rd., Damascus, Md. 20872 | | | | | | | | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

IMMEDIATE CAUSE (Final disease or condition resulting in death) → Cardiac Arrest
Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
<table border="0"> <tr> <td>a. Cardiac Arrest</td> <td>Approximate Interval Between Onset and Death</td> </tr> <tr> <td>b. Coronary Artery disease</td> <td>30yrs</td> </tr> <tr> <td>c. Pneumonia</td> <td>3 weeks</td> </tr> <tr> <td>d. Multi infarct Dementia</td> <td>3 yrs</td> </tr> </table> | | | | | | | a. Cardiac Arrest | Approximate Interval Between Onset and Death | b. Coronary Artery disease | 30yrs | c. Pneumonia | 3 weeks | d. Multi infarct Dementia | 3 yrs |
| a. Cardiac Arrest | Approximate Interval Between Onset and Death | | | | | | | | | | | | | |
| b. Coronary Artery disease | 30yrs | | | | | | | | | | | | | |
| c. Pneumonia | 3 weeks | | | | | | | | | | | | | |
| d. Multi infarct Dementia | 3 yrs | | | | | | | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
CVA | | | | | | | 24a. WAS AN AUTOPSY PERFORMED?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | | | | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
<input type="checkbox"/> YES <input type="checkbox"/> NO | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input checked="" type="checkbox"/> DOA
OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | | | | | | |
| 27. MANNER OF DEATH
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY
(Month, Day, Year) | | 28b. TIME OF INJURY
M | | 28c. INJURY AT WORK?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | | | | | |
| | | 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | |
| 29a. CERTIFIER (Check only one)
<input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
<i>Alan Rohrer, MD</i> | | | | 29c. LICENSE NUMBER
D37197 | | 29d. DATE SIGNED (Month, Day, Year)
5-11-96 | | | | | | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
1 N. Main St. Mt. Airy, MD Alan Rohrer, M.D. | | | | | | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
MAY 13 1996 | | 32. REGISTRAR'S SIGNATURE
<i>John Shuler-Randall</i> | | | | | | | | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 15991

Certificate of Death

Reg. No.

| | | | | | | | | | |
|---|--|--|--|--|--|--|---|---|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Gary Wayne Clutter | | | | 2. Date of Death
Month May , Day 6 , Year 1996 | | 3. Time of Death
12:12 P.M. | | |
| | 4e. Facility Name (If not institution, give street and number)
4304 Mica Ct. | | | | 4b. City, Town, or Location of Death
Middletown | | 4c. County of Death
Frederick | | |
| Funeral
Director | 5. Social Security Number
232-70-6522 | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday)
49 Yrs. | | 8. Date of Birth (Month, Day, Year)
MAR. 23, 1947 | | |
| | 9. Birthplace (State or Foreign Country)
W. Va. | | 10a. State
Md. | | 10b. County
Frederick | | 10c. City, Town or Location
Middletown | | |
| Usual Residence of Decedent | | 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 10e. Street and Number
4304 Mica Ct. | | 10f. Zip Code
21769 | | 10g. Citizen of What Country?
U.S.A. | |
| 11. Marital Status
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
If Yes, Give Year or Dates: 1964-1974 | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: White | | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 1 College (1-4 or 5+) | | 16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
hospital warehouseman | | 16b. Kind of Business/Industry
federal government | | | | | |
| 17. Father's Name (First, Middle, Last)
Wade S. Clutter | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Bertha Riggle | | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
Judith McG. Clutter | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
4304 Mica Ct., Middletown, Md. 21769 | | | | | |
| 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Rocky Gap Veteran's Cemetery | | 20c. Location - City or Town, State
5/10 Cumberland, Md. | | | | | |
| 21. Signature of Funeral Service Licensee
 | | | | 22. Name and Address of Facility
Donald B. Thompson Funeral Home
31 E. Main St., Middletown, Md. 21769 | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
e. arteriosclerotic cardiovascular disease
Due to (or as a consequence of):

b.
Due to (or as a consequence of):

c.
Due to (or as a consequence of):

d.
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | | Approximate Interval Between Onset and Death
hours | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
chronic alcoholism
hypertension
chronic obstructive pulmonary disease | | | | | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | |
| | | | | | | | | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| | | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No | |
| 25. Was case referred to medical examiner?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation
<input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined
<input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input type="checkbox"/> No | | 28d. Describe how injury occurred | |
| | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. Certifier (Check only one)
<input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier
 | | 29c. License number
D09867 | | 29d. Date signed (Month, Day, Year)
5/6/96 | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Robert R. R. Roberts, M. D. 7501B McKaig Rd., Frederick, Md. 21701-3319 | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
MAY 13 1996 | | 32. Registrar's Signature
 | | | | | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 15992

Certificate of Death

Reg. No.

| | | | | | | | | |
|---|---|--|---|--|--|---|---|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
WILLIAM EGAN COLBY | | | | 2. Date of Death
Month Day Year
MAY 06, 1996 | | 3. Time of Death
0855 AM | |
| | 4a. Facility Name (If not institution, give street and number)
END OF ROCK POINT ROAD | | | | 4b. City, Town, or Location of Death
COBB ISLAND | | 4c. County of Death
CHARLES | |
| Funeral
Director | 5. Social Security Number
577-28-7679 | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)
76 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth (Month, Day, Year)
Jan. 4, 1920 | | 9. Birthplace (State or Foreign Country)
St. Paul, Minn. |
| | Usual Residence of Decedent | | | | 10c. City, Town or Location
Washington, D.C. | | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | |
| To Be Completed by Funeral Director | 10a. State
none | 10b. County
none | | | | | | |
| | 10e. Street and Number
3028 Dent Place, N.W. | | | 10f. Zip Code
20007 | | 10g. Citizen of What Country?
U.S.A. | | |
| | 11. Marital Status
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: White | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Attorney at Law | | 16b. Kind of Business/Industry
Consultant | | | |
| | 17. Father's Name (First, Middle, Last)
Elbridge Colby | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Margaret Egan | | | |
| | 19a. Informant's Name/Relationship (Type, Print)
Sally Shelton-Colby | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
3028 Dent Place, N.W. Washington, D.C. 20007 | | | |
| | 20a. Method of Disposition
<input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Metropolitan Crematory | | 20c. Location - City or Town, State
5-10-96 Alexandria, Virginia | | | |
| | 21. Signature of Funeral Service Licensee
 | | 22. Name and Address of Facility
DeVol Funeral Home
2222 Wisconsin Avenue, N.W. Washington, DC 20007 | | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
Immediate Cause (Final disease or condition resulting in death)
Drowning and hypothermia associated with
a. Arteriosclerotic cardiovascular disease
Due to (or as a consequence of):
Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of): | | | | | | | |
| | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | | | | | 24a. Was an autopsy performed?
yes
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | |
| 24b. Were autopsy findings available prior to completion of cause of death?
yes
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | | |
| 25. Was case referred to medical examiner?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) WATER | | | | |
| 27. Manner of Death
<input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day, Year)
Found: 5/6/96 | | 28b. Time of Injury
8:10A M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred
Fell from canoe into water |
| | | 28e. Place of Injury - At home, term, street, factory, office building, etc. (Specify)
water | | 28f. Location (Street and Number or Rural Route Number, City or Town, State)
Near Cobb Island, Maryland | | | | |
| 29a. Certifier (Check only one)
<input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | |
| 29b. Signature and title of certifier
 | | | | 29c. License number
O.C.M.E | | 29d. Date signed (Month, Day, Year)
MAY 6, 1996 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
David R Fowler 111 Penn Street, Baltimore, Maryland 21201 | | | | | | | | |
| 31. Date filed (Month, Day, Year)
MAY 13 1996 | | | | 32. Registrar's Signature
 | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 23b is marked any injury or other traumatic event, the Medical Examiner must be notified at once.

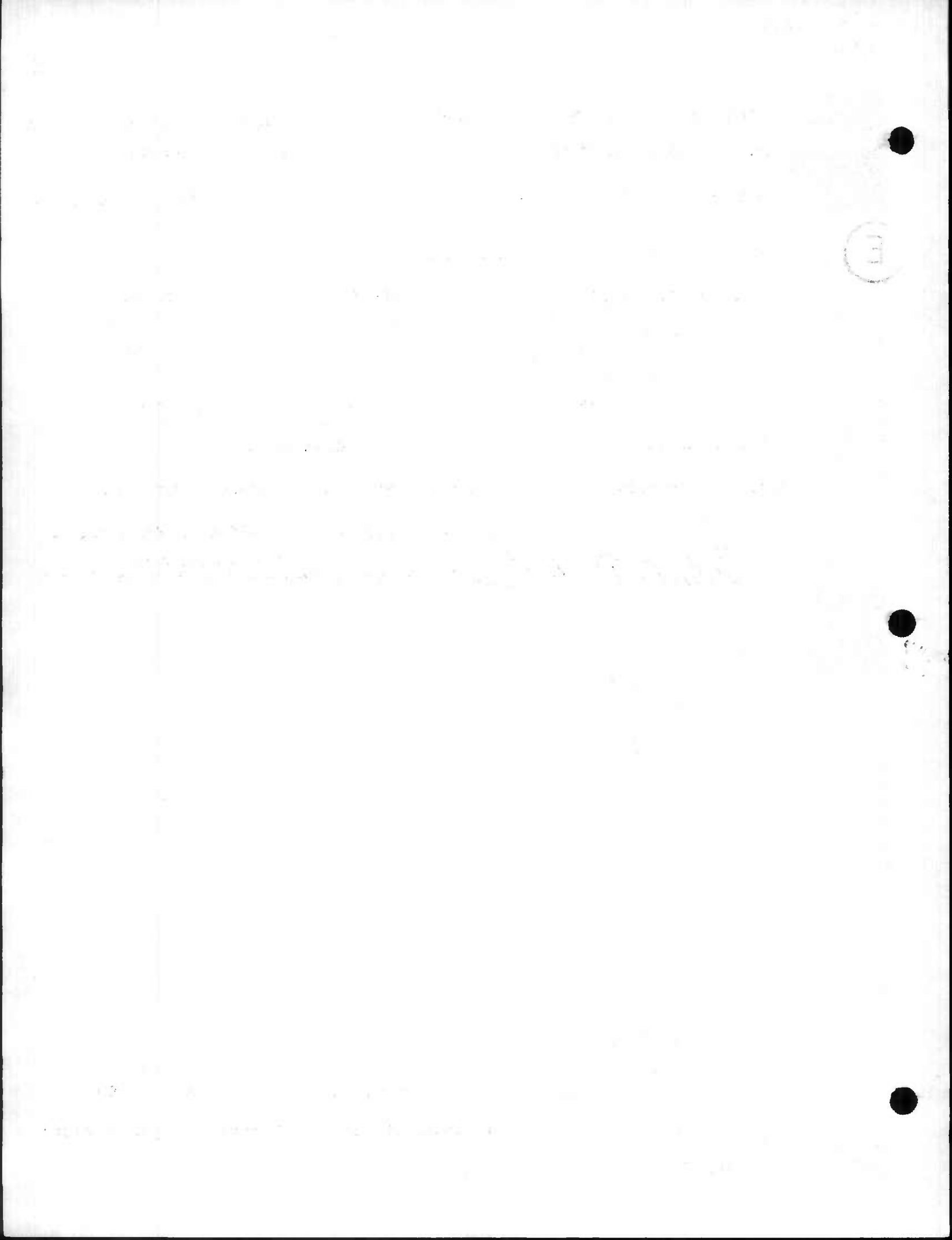
Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

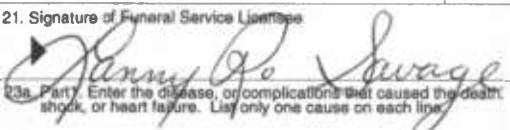
To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene
Certificate of Death

96 15993

Reg. No.

| | | | | | | | | | | |
|---|--|--|---|--|---|---|--|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
George William Dalton | | | | | 2. Date of Death
Month May Day 21 Year 1996 | | 3. Time of Death
10:27 A.M. | | |
| | 4a. Facility Name (If not institution, give street and number)
275 Maplewood Drive | | | | | 4b. City, Town, or Location of Death
Walkersville | | 4c. County of Death
Frederick | | |
| Funeral
Director | 5. Social Security Number
013-05-3229 | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)
83 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth (Month, Day, Year)
Sept. 8, 1912 | | 9. Birthplace (State or Foreign Country)
Massachusetts | |
| | Usual Residence of Decedent | | | | | | | | | |
| 10a. State
Maryland | | | 10b. County
Frederick | | 10c. City, Town or Location
Walkersville | | | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | |
| 10e. Street and Number
275 Maplewood Drive | | | | | 10f. Zip Code
21793 | | 10g. Citizen of What Country?
United States | | | |
| 11. Marital Status
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc.
Specify: White | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (1-4or 5+) | | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Service Manager | | | 16b. Kind of Business/Industry
Diebold, Inc. | | |
| 17. Father's Name (First, Middle, Last)
George W. Dalton | | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Margaret Carey | | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
Richard P. Dalton, son | | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
275 Maplewood Drive Walkersville, MD 21793 | | | | | |
| 20a. Method of Disposition
<input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Hagerstown Crematory | | Date
5/23/96 | | 20c. Location - City or Town, State
Hagerstown, Maryland | | | |
| 21. Signature of Funeral Service Licensee
 | | | | | 22. Name and Address of Facility
Stauffer Funeral Homes, P.A.
1621 Opossumtown Pike Frederick, Maryland 21702 | | | | | |
| 23a. Enter the disease, or complications that caused the death, shock, or heart failure. List only one cause on each line.
Lung Cancer | | | | | | | | | | |
| 23b. Did tobacco use contribute to the cause of death?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | | | | | | |
| 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | | | | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | | | |
| 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input type="checkbox"/> No | | 28d. Describe how injury occurred | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | | | |
| 29b. Signature and title of certifier
Michael Lerner M.D. | | | | | 29c. License number
D41619 | | 29d. Date signed (Month, Day, Year)
May 22, 1996 | | | |
| 30. Name and address of person who completed cause of death (item 23a) (Type, Print)
Dr. Michael Lerner, M.D. 15 E. Frederick Street Walkersville, Maryland 21793 | | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
MAY 23 1996 | | | 32. Registrar's Signature
 | | | | | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

State
Registrar

96 15994

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
JEAN DOLORES DeLASHMUTT | | | | 2. DATE OF DEATH
MONTH DAY YEAR
May 16, 1996 | | 3. TIME OF DEATH
1:30 A M | |
| 4. SOCIAL SECURITY NUMBER
217-28-1323 | | 5. SEX
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
63 YRS. | | 7. DATE OF BIRTH (Month, Day, Year)
April 30, 1933 | |
| 9a. FACILITY NAME (If not Institution, give street and number)
6319 Clevelandtown Road | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
Boonsboro | | 9c. COUNTY OF DEATH
Frederick | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE
Maryland | | 10b. COUNTY
Frederick | | 10c. CITY, TOWN OR LOCATION
Boonsboro | | 10d. INSIDE CITY LIMITS?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 10e. STREET AND NUMBER
6319 Clevelandtown Road | | | | 10f. ZIP CODE
21713 | | 10g. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 11. MARITAL STATUS
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify: White | |
| 15. DECEDENT'S EDUCATION
(Specify only highest grade completed)
Elementary/Secondary (0-12) 12
College (1-4 or 5+) College (1-4 or 5+) | | 15a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.)
House Cleaner | | 15b. KIND OF BUSINESS/INDUSTRY
None | | | |
| 17. FATHER'S NAME (First, Middle, Last)
John Covell | | | | 16. MOTHER'S NAME (First, Middle, Maiden Surname)
Grace McBride | | | |
| 19a. INFORMANT'S NAME (Type/Print)
Kelly M. LaTorre | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
778-D Wembley Drive, Frederick, MD 21701 | | | |
| 20a. METHOD OF DISPOSITION
1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
Smithsburg Crematory | | DATE
5/16 | | 20c. LOCATION — City or Town, State
Smithsburg, Maryland | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
 | | 22. NAME AND ADDRESS OF FACILITY
ROBERT E. DAILEY & SON FUNERAL HOMES, P.A.
1201 NORTH MARKET ST., FREDERICK, MD 21701 | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Lung Cancer
DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST
b. DUE TO (OR AS A CONSEQUENCE OF):
c. DUE TO (OR AS A CONSEQUENCE OF):
d. | | | | | | | Approximate Interval Between Onset and Death
4 mo |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | 24a. WAS AN AUTOPSY PERFORMED?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA
OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation
2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined
3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year)
N.A. | | 28b. TIME OF INJURY
M | | 28c. INJURY AT WORK?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28d. DESCRIBE NOW INJURY OCCURRED | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. CERTIFIER (Check only one)
1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
 | | | | 29c. LICENSE NUMBER
D16931 | | 29d. DATE SIGNED (Month, Day, Year)
5/16/96 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
Michael R. Behre, M.D. South Church & Franklin Streets, Middletown MD 21769 | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
MAY 17 1996 | | 32. REGISTRAR'S SIGNATURE
 | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 6876

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

96 15995

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|---|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
MARY JOSEPHINE DUCKETT | | | | 2. DATE OF DEATH
MONTH DAY YEAR
May 11 1996 | | 3. TIME OF DEATH
12:30 P^M | |
| 4. SOCIAL SECURITY NUMBER
214-42-2999 | | 5. SEX
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
71 YRS. | | 7. DATE OF BIRTH (Month, Day, Year)
Mar 2 1925 | |
| 8. BIRTHPLACE (State or Foreign Country)
Illinois | | | | 9. FACILITY NAME (If not institution, give street and number)
Shady Grove Adventist Hospital | | | |
| 10. STATE
MD | | | | 10b. COUNTY
Montgomery | | 10c. CITY, TOWN OR LOCATION
Poolesville | |
| 10d. INSIDE CITY LIMITS?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | 10e. STREET AND NUMBER
16000 Partnership Road | | | |
| 10f. ZIP CODE
20837 | | | | 10g. CITIZEN OF WHAT COUNTRY?
USA | | | |
| 11. MARITAL STATUS
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify: white | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12) 1 College (1-4 or 5+) 1 | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
self-employed | | 16b. KIND OF BUSINESS/INDUSTRY
Garden Center | | | |
| 17. FATHER'S NAME (First, Middle, Last)
Harry Williams | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Katherine Walker | | | |
| 19a. INFORMANT'S NAME (Type/Print)
Mary Jo Duckett | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
4635 Mt. Horeb Rd. Lexington, KY 40511 | | | |
| 20a. METHOD OF DISPOSITION
1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
Smithsburg 5/12 Smithsburg, MD | | 20c. LOCATION — City or Town, State | | 20d. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
<i>Wm C. Hill</i> | | | | 22. NAME AND ADDRESS OF FACILITY
Hilton Funeral Home
Barnesville, MD 20838 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Metastatic Papillary Carcinoma consistent with endometrial primary (md)
DUE TO (OR AS A CONSEQUENCE OF):
b. Renal cancer
DUE TO (OR AS A CONSEQUENCE OF):
c. _____
DUE TO (OR AS A CONSEQUENCE OF):
d. _____
Approximate interval Between Onset and Death
2yr | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation
2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide
3 <input type="checkbox"/> Homicide 7 <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M | | 28c. INJURY AT WORK?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28e. DESCRIBE HOW INJURY OCCURED | | | | | |
| 29a. CERTIFIER (Check only one)
1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. SIGNATURE AND TITLE OF CERTIFIER
<i>Mosela Beloshin MD</i> | | 29c. LICENSE NUMBER
D43369 | | 29d. DATE SIGNED (Month/Day/Year)
5/11/96 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
Poolesville MD | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
MAY 13 1996 | | 32. REGISTRAR'S SIGNATURE
<i>John Davidson Randall</i> | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 15996

Certificate of Death

Reg. No.

| | | | | | | | | | | | | | |
|--|--|------------------------|--|---|---|---|--|--|--|---|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Samuel Roland Dorsey | | | | 2. Date of Death
Month Day Year
May 3, 1996 | | | | 3. Time of Death
7:02 P.M. | | | | |
| | 4a. Facility Name (If not institution, give street and number)
Frederick Health Care Center | | | | 4b. City, Town, or Location of Death
Frederick | | | | 4c. County of Death
Frederick | | | | |
| Funeral
Director | 5. Social Security Number
216-14-7767 | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday)
72 Yrs. | | 8. Date of Birth (Month, Day, Year)
Dec. 24, 1923 | | 9. Birthplace (State or Foreign Country)
Maryland | | | | |
| | Usual Residence of Decedent | | | | | | | | | | | | |
| 10a. State
Maryland | | 10b. County
Carroll | | 10c. City, Town or Location
Mt. Airy | | | | 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | |
| 10e. Street and Number
3851 W. Watersville Road | | | | 10f. Zip Code
21771 | | | | 10g. Citizen of What Country?
United States | | | | | |
| 11. Marital Status
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | | 12. Was Decedent Ever in U.S. Armed Forces?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
If Yes, Give Year or Dates: WWII | | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc.
Specify: White | | | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 Collega (1-4or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Policeman | | | | 16b. Kind of Business/Industry
Maryland State Police | | | | | |
| 17. Father's Name (First, Middle, Last)
Roland Albert Dorsey | | | | | | 18. Mother's Name (First, Middle, Maiden Summa)
Nellie Norwood | | | | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
Barbara Anne Domer, daughter | | | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1340 Orchard Way Frederick, Maryland 21703 | | | | | | | |
| 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory, or other place)
Pine Grove Cemetery | | | | 20c. Location - City or Town, State
Mt. Airy, Maryland | | 20d. Date
5/9/96 | | | |
| 21. Signature of Funeral Service Licensee
 | | | | | | 22. Name and Address of Facility
Stauffer Funeral Home, Inc.
8 E. Ridgeville Blvd. Mt. Airy, MD 21771 | | | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. END STAGE LIVER CIRRHOSIS
Dua to (or as a consequence of):

b.
Dua to (or as a consequence of):

c.
Dua to (or as a consequence of):

d.
Dua to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last | | | | | | | | | | | | Approximate Interval Between Onset and Death
6 MONTHS | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | | | |
| | | | | | | | | 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | |
| 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one)
Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | | | |
| 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation
2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined
3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how Injury occurred | | | |
| | | | | 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | | | | |
| 29b. Signature and title of certifier
Neil Warandekar MD | | | | | | 29c. License number
D47611 | | 29d. Date signed (Month, Day, Year)
5/8/96 | | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
NEIL WARANDEKAR, MD 1475 TANEY AVE., #204, FREDERICK, MD 21702 | | | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
MAY 09 1996 | | | | 32. Registrar's Signature
 | | | | | | | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

1. The first part of the report deals with the general situation of the country and the progress of the work during the year. It is a summary of the work done and the results obtained.

2. The second part of the report deals with the work done in the various departments. It is a detailed account of the work done in each department and the results obtained.

3. The third part of the report deals with the work done in the various sections. It is a detailed account of the work done in each section and the results obtained.

4. The fourth part of the report deals with the work done in the various divisions. It is a detailed account of the work done in each division and the results obtained.

5. The fifth part of the report deals with the work done in the various branches. It is a detailed account of the work done in each branch and the results obtained.

6. The sixth part of the report deals with the work done in the various departments. It is a detailed account of the work done in each department and the results obtained.

7. The seventh part of the report deals with the work done in the various sections. It is a detailed account of the work done in each section and the results obtained.

8. The eighth part of the report deals with the work done in the various divisions. It is a detailed account of the work done in each division and the results obtained.

9. The ninth part of the report deals with the work done in the various branches. It is a detailed account of the work done in each branch and the results obtained.

96 15998

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
Mary Rose Day | | | | 2. DATE OF DEATH
MONTH DAY YEAR
May 13, 1996 | | 3. TIME OF DEATH
M
7:15 am | |
| 4. SOCIAL SECURITY NUMBER
222-12-8317 | | 5. SEX
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
70 YRS. | | 7. DATE OF BIRTH (Month, Day, Year)
Oct. 27, 1925 | |
| 9a. FACILITY NAME (If not institution, give street and number)
6 Gerard Court | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
Rockville | | 9c. COUNTY OF DEATH
Montgomery | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE
CA | | 10b. COUNTY
Orange | | 10c. CITY, TOWN OR LOCATION
Irvine | | 10d. INSIDE CITY LIMITS?
1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER
18 Mt. View | | | | 10f. ZIP CODE
92715 | | 10g. CITIZEN OF WHAT COUNTRY?
United States | |
| 11. MARITAL STATUS
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12) 12
College (1-4 or 5+) College | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
Graduate Advisor | | 16b. KIND OF BUSINESS/INDUSTRY
Academic | | | |
| 17. FATHER'S NAME (First, Middle, Last)
Samuel Santucci | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Maria Divitantonio | | | |
| 19a. INFORMANT'S NAME (Type/Print)
Ralph Nitkin | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
6 Gerard Ct Rockville MD 20850 | | | |
| 20a. METHOD OF DISPOSITION
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
Pacific View Mem. Park | | DATE
5/17 | | 20c. LOCATION — City or Town, State
Corona Del Mar, CA | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
 | | | | 22. NAME AND ADDRESS OF FACILITY
Edward Sagel Funeral Direction
1091 Rockville, MD 20852 | | | |
| 23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. METASTATIC NONSMALL CELL LUNG CANCER
DUE TO (OR AS A CONSEQUENCE OF):
b. DUE TO (OR AS A CONSEQUENCE OF):
c. DUE TO (OR AS A CONSEQUENCE OF):
d. DUE TO (OR AS A CONSEQUENCE OF):
Approximate Interval Between Onset and Death 9 MONTHS | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | | | | |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | | | | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA
OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation
2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined
3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M | | 28c. INJURY AT WORK?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | 28g. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one)
1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
Carolyn B Hendricks MD | | | | 29c. LICENSE NUMBER
D37236 | | 29d. DATE SIGNED (Month, Day, Year)
MAY 13, 1996 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
CAROLYN B HENDRICKS, MD #300 ROCKVILLE, MD 20815 | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
MAY 15, 1996 | | | | 32. REGISTRAR'S SIGNATURE
John A. Davidson-Randall | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene
Certificate of Death

96 15999

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

MELVIN DESSER

2. Date of Death

Month Day Year
MAY 14 1996

3. Time of Death

6:50 AM

4a. Facility Name (If not institution, give street and number)

SINAI HOSPITAL

4b. City, Town, or Location of Death

BALTIMORE CITY

4c. County of Death

Funeral
Director

5. Social Security Number

215-03-7791

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

81 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Month Day Year
MAY 31, 1914

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

3031 FALSTAFF ROAD #206

10f. Zip Code

21209

10g. Citizen of What Country?

UNITED STATES

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
11

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

OWNER/PROPRIETOR

16b. Kind of Business/Industry

PRIVATE INDUSTRY

17. Father's Name (First, Middle, Last)

SOLOMON WOLF DESSER

18. Mother's Name (First, Middle, Maiden Surname)

HELEN COHEN

19a. Informant's Name/Relationship (Type, Print)

BARBARA DESSER (WIFE)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3031 FALSTAFF ROAD #206 - BALTIMORE, MD. 21209

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

BETH JACOB CEMETERY

Date

5/15/96

20c. Location - City or Town, State

FINKSBURG, MARYLAND

21. Signature of Funeral Service Licensee

Frank A. Stone

22. Name and Address of Facility

DANZANSKY-GOLDBERG MEMORIAL CHAPELS, INC.
1170 ROCKVILLE PIKE - ROCKVILLE, MD. 20852

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. CEREBRAL HEMATOMA

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

14 days

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient

2 ☐ ER/Outpatient

3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home

5 ☐ Residence

8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician

2 ☐ Medical Examiner

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. In my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

John R. ...

29c. License number

RESIDENT IN SURGERY SINAI PR#1681

29d. Date signed (Month, Day, Year)

MAY 14, 1996

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JOHN R. ... DEPT OF SURGERY, SINAI HOSPITAL, BALTIMORE MD

31. Date filed (Month, Day, Year)

MAY 17 1996

32. Registrar's Signature

John R. ...

State
Registrar

3

96 16000

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
JOSEPHINE MARY EPSTEIN | | | | 2. DATE OF DEATH
MONTH 05 DAY 08 YEAR 96 | | 3. TIME OF DEATH
1047A | |
| 4. SOCIAL SECURITY NUMBER
260-36-3897 | | 5. SEX
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 8. AGE (In yrs. last birthday)
82 YRS. | | 7. DATE OF BIRTH (Month, Day, Year)
March 14, 1914 | |
| 9a. FACILITY NAME (If not institution, give street and number)
13507 Old Annapolis Road | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
Mt. Airy | | 9c. COUNTY OF DEATH
Frederick | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE
Maryland | | 10b. COUNTY
Frederick | | 10c. CITY, TOWN OR LOCATION
Mt. Airy | | 10d. INSIDE CITY LIMITS?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 10e. STREET AND NUMBER
13507 Old Annapolis Road | | | | 10f. ZIP CODE
21771 | | 10g. CITIZEN OF WHAT COUNTRY?
United States | |
| 11. MARITAL STATUS
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12) 12
College (1-4 or 5+) _____ | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
Homemaker | | 16b. KIND OF BUSINESS/INDUSTRY
Own Home | | | |
| 17. FATHER'S NAME (First, Middle, Last)
Boleslaw Malaskiewicz | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Mary Pierog | | | |
| 19a. INFORMANT'S NAME (Type/Print)
Michael S. Epstein | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
13507 Old Annapolis Road, Mt. Airy, Maryland. 21771 | | | |
| 20a. METHOD OF DISPOSITION
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) _____ | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
Arlington National Cemetery 5/16 | | 20c. LOCATION — City or Town, State
Arlington, Virginia | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
<i>James L. Williams</i> | | | | 22. NAME AND ADDRESS OF FACILITY
Olin L. Molesworth P.A., Funeral Home
26401 Ridge Road Damascus, Maryland. 20872 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | | a. ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE
DUE TO (OR AS A CONSEQUENCE OF): | | | | | Approximate interval Between Onset and Death
HOURS |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | b. HYPERTENSION
DUE TO (OR AS A CONSEQUENCE OF): | | | | | YEARS |
| | | c. _____
DUE TO (OR AS A CONSEQUENCE OF): | | | | | |
| | | d. _____
DUE TO (OR AS A CONSEQUENCE OF): | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> OOA
OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) _____ | | | | | |
| 27. MANNER OF DEATH
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation
2 <input type="checkbox"/> Accident 8 <input type="checkbox"/> Could not be determined
3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M | | 28c. INJURY AT WORK?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| | | 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. CERTIFIER (Check only one)
1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
<i>Robert R. Roberts MD</i> | | | | 29c. LICENSE NUMBER
D09867 | | 29d. DATE SIGNED (Month, Day, Year)
05/08/96 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
R R R ROBERTS MD 75 0113 MCKAIG RD FREDERICK MD 21701-3319 | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
MAY 13 1996 | | 32. REGISTRAR'S SIGNATURE
<i>John A. ...</i> | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 5 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

